THE HEALTH OF THE NATION

A CONSULTATIVE DOCUMENT FOR HEALTH IN ENGLAND

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HEALTH IN ENGLAND

Presented to Parliament

by the Secretary of State for Health

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Foreword by William Waldegrave, Secretary of State for Health

As we approach the next millenium it is timely to look forward to what we in England want to achieve by way of further improvements to our health.

2 In the last few years attention has concentrated on improving the management of the National Health Service. Significant changes have been made to the way family health, community and hospital services are organised. The purpose of the reform was to give the Health Service a much greater capacity explicitly to address the health needs of the country. This consultative document shows how the reformed NHS can, with the Department of Health and others, play its part in identifying those needs and developing policies to meet them.

3 A key feature of the reforms has been the establishment of a clear strategic role for health authorities. For too long health authorities have been preoccupied with the – very real – problems of day-to-day management of services. This has been to the detriment of their strategic role of maintaining and improving the health of their local people. Paradoxically, it has also been argued to have been to the detriment of the services themselves, where local managers and clinicians have not felt they have been left free to manage.

4 The reforms have established that the prime role of health authorities is an explicit responsibility for the health of their residents. Their job, as "champions of the people", is threefold:

- **First**, to assess the state of health of the people they serve
- **Second**, to obtain the services needed to ensure effective action is taken to maintain good health, prevent and treat ill-health, rehabilitate people to good health, and provide support and care for those who are disabled, chronically ill or dying
- **Third**, to ensure the quality and effectiveness – including cost effectiveness – of the services their residents use.

5 These changes at local level have been matched by complementary changes at national level. Not least of these is the establishment, within the Department of Health, of the NHS Management Executive whose task is to improve the 'head office' function of the NHS and ensure that responsibilities delegated to local level are effectively discharged and performance properly monitored and reviewed.

6 However, the reforms also refocus the Department's attention on the broader public health issues which often go beyond the responsibilities of the NHS. It is often forgotten that the Department of Health's predecessor Ministry was established in 1919, long before the creation of the NHS. Its origins lay in the great public health reforms of the second half of the 19th century. The 1919 Act required my predecessor the Minister of Health to "take all such steps as may be desirable to secure the preparation, effective carrying out and co-ordination of measures conducive to the health of the people". Only later came my NHS responsibilities for the prevention, diagnosis and treatment of ill-health. The exercise of these central Government responsibilities has not been in abeyance, but their importance and the attention we pay to

them need now to be brought into a better balance with the attention we rightly pay to the National Health Service. The changes allow this to happen. The strategic role of the Department of Health is clear. Its task is to monitor and assess the health of the nation and take the action necessary, or ensure that the action is taken, whether through the NHS or otherwise, to improve and protect health.

7 This document describes how we might best go about developing this new health initiative. It sets in train the generation, effectively for the first time in England, of national and local health objectives and targets within a strategic framework. Parallel steps are being taken by my colleagues in Scotland, Wales and Northern Ireland.

8 A variety of public authorities have a role to play. Historically, the nineteenth century reforms involved many Departments and institutions of Government. We now accept as the norm the availability of clean water, effective sewerage systems, the absence of vermin, clean air, safe food, regular waste collection and disposal, and street cleansing. We also now accept that part of the justification for providing financial support for certain groups of the population and the need for a decent home to be put within the reach of every family are related to health. Today, therefore, not only Government Departments, but also local authorities, public water and sewerage companies, HM Inspectorate of Pollution, the Health and Safety Executive, and many other bodies have a continuing role in safeguarding our health. Their contributions to this health strategy, therefore, should be acknowledged and, where practicable, co-ordinated.

9 But the national health objectives and targets and associated initiatives which this document proposes are not for the authorities alone. Government cannot by itself secure the health of the population: that can only be secured by persuading ordinary citizens that it is worth doing and securing their commitment, co-operation and concerted action. Likewise, objectives and targets have to be broadly accepted if they are to be of value – not just by professionals but more widely.

10 The discussion and ideas in this document speak, I hope, for themselves. However, there are three points I wish to emphasise:

- **First**, a major theme of this document is the prevention of ill-health and promotion of good health. It must be right to redouble our efforts to reduce avoidable disease and premature death. This must *not*, however, be at the expense of caring for ill people and treating illness, of effective rehabilitation after accident or illness, or of looking after the infirm and dying. We need to find the right balance between what Beveridge identified as the three key areas: prevention, treatment and rehabilitation.

- **Second**, there is considerable emphasis in this document on the need for people to change their behaviour – whether on smoking, alcohol consumption, exercise, diet, avoidance of accidents and, with AIDS, sexual behaviour. The reason is simple. We live in an age where many of these main causes of premature death and unnecessary disease are

related to how we live our lives. For too long, however, the health debate has been bedevilled by the two extreme claims of, on the one hand, "It's all up to individuals" and, on the other, "It's all up to Government". We need a proper balance between individual responsibility and Government action. Government must ensure that individuals have the necessary information with which they can exercise informed free choice. Education is the key. Equally, Government undertakes a variety of measures designed to ensure that people live in physical and social circumstances where such free choice is possible. Nonetheless, where law or regulation is concerned, it is Government which must take effective action on behalf of individuals and their families. In between Government and individual stands a range of organisations – statutory authorities, voluntary bodies, health professionals and others – whose activities will be more effective if exercised within a broad agreement about goals. You cannot in the end coerce people into good health. That is why we need mutual agreement on priorities and on how best to work together to improve our health.

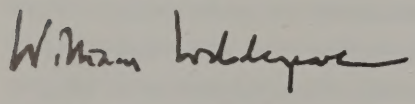
• **Third**, I am convinced that setting objectives and targets for improvements in health is an essential discipline. Much of this document is based on that conviction. But we must get the targets right. They must be sufficiently challenging, yet not so daunting that they become a disincentive to achievement. A key purpose of this consultative document is to focus debate on a number of alternative objectives and targets. Others may wish to propose additional targets. It is important to recognise, however, that priorities are meaningless if they include everything. Not every deserving objective can be a priority. Further, if targets are to be of any use, they must be defined. There must be a clear understanding of how the setting of targets can be carried forward into effective action to meet them. The converse of this is that by raising the priority of certain areas where a concerted effort can bring major rewards, we are not lessening our commitment to steady progress across the board by means of comprehensive health provision policies. Over the past ten years, expenditure on the NHS has been increased by almost half in real terms. However, resources which can be devoted to health care will always be finite in the face of infinite demand. Setting priorities is therefore essential. Through the NHS Management Executive, I will hold Regional Health Authorities accountable for seeing that District Health Authorities'/Family Health Services Authorities' contracts embody action to take forward our priorities once they are agreed.

11 The development of a health strategy is a new concept for England. The NHS reforms give us for the first time a firm foundation on which to build. We can now think strategically about the future direction of health. We are clear about one thing: a strategy imposed by Government which takes no heed of the views of those who will have to implement it, including the people themselves, is valueless. Implementation depends, in the current jargon, on shared 'ownership'. Health is determined by a wide range of influences.

Responsibilities for action are similarly widely spread from individuals to Government. Commitment – shared commitment – to a health strategy for England is essential. Hence this document initiates the active consultative process which is described in the final chapter.

12 The consultation will be to the end of October 1991 and be positive and comprehensive. To encourage widespread participation we are also publishing at the same time a short leaflet on our proposals. In addition, the Department of Health and the NHS will jointly be establishing a number of groups to look in more detail at specific issues raised. The results of consultation and the work of these groups will influence a second **Health of the Nation** document to be published later. This will set out the way forward proposed in the light of the consultation. Complete agreement may be unattainable. But it is right to seek as much common ground as possible.

13 I look forward to your responses and the discussions I am confident this document will stimulate.



WILLIAM WALDEGRAVE June 1991
Secretary of State for Health
Whitehall
LONDON

THE HEALTH OF THE NATION

"The Health of the Nation" is a discussion document which sets out for consultation the Government's proposals for the development of a health strategy for England.

The Government believes the time is now right to develop a health strategy for England. The recent series of reforms affecting health and health care provide significant new opportunities for improving the health of the country. In addition, since the process of reform has inevitably concentrated attention on mechanisms and means rather than ends, the Government believes attention must now be focused on the improvements in health which were the aim of the reforms.

2 The value of a strategy is that it clarifies aims and responsibilities, focuses action and sets a framework against which progress can be measured. Its ultimate purpose is to improve further the span of healthy life of the people of England.

THE POLICY OBJECTIVES

3 The key policy objectives and guiding principles which underpin the proposals are the need:

- to identify the main health problems and focus on them;
- to focus as much on the promotion of good health and the prevention of disease as on the treatment, care and rehabilitation of those who fall ill or who need continual support, whilst ensuring that work on either is not at the expense of the other – there must be no lessening of the NHS's role to provide high quality services to meet changing or increasing demands;
- to recognise that as health is determined by a whole range of influences – from genetic inheritance, through personal behaviour, family and social circumstances to the physical and social environment – so opportunities and responsibilities for action to improve health are widely spread from individuals to Government as a whole;
- to recognise that the concerted action needed calls for greater co-operation between those involved, at national and local level, within and outside the NHS;
- to secure a proper balance between central strategic direction and local and individual discretion, flexibility and initiative; and ensure that where responsibilities are devolved there is fair, but rigorous, scrutiny of performance and outcomes;
- to secure the best possible use of available resources – resources have grown considerably in recent years, but they will always be finite. There are competing demands in society for expenditure by Government. Making the best possible use of available resources – money and people – is therefore an important objective.

4 The Government recognises that the achievement of these objectives in turn means:

- improving the ability both to monitor the state of the people's health and to evaluate the health benefits of policies and programmes, and the ability to assess the effectiveness – in terms of 'health gains' – of particular services and practices;

- ensuring everyone has the best possible information they need to understand the influences on their health, especially the influence of their own behaviour, and the necessary support to improve their health;

- involving people more – individually and through local and voluntary organisations – at both strategic and operational levels in discussion and decisions about options and priorities, and through that involvement generating a shared commitment.

KEY OBJECTIVES AND TARGETS

5 Central to the Government's suggested approach is the need to identify and agree clear objectives and specific targets for improvements in health.

THE HEALTH OF THE NATION: THE CHALLENGES

6 The last 100 years have seen a transformation in the health of the people of England. Continued vigilance is needed to sustain the improvements. And there are still formidable challenges:

- many people still die prematurely or suffer debilitating ill-health from conditions – diseases, accidents – which are to a large extent preventable.

- many of these causes of death and ill-health are known to be preventable both in principle and from comparison with performance in other countries, and within England. Moreover, in practice the levels of death and ill-health can be reduced if effective action is taken.

- there are significant variations in health – geographical, ethnic, social and occupational – within England as in other countries. This is a cause for concern and a challenge: concern, because there is often no known intrinsic reason for their existence; a challenge, because, like comparisons with other countries, they indicate the possibility for improvement.

- despite significant progress – and what the NHS has achieved is formidable – there are still variations in the quantity and quality of health care in different parts of the country.

7 What needs to be done? Key are the need

- to increase understanding of the state of the population's health and what influences it

- to reduce exposure to risks from people's own behaviour or the environment which damage health

- to take action to ensure that people are properly informed and have the freedom to

exercise choice. People cannot be forced to behave sensibly in terms of their smoking, eating, exercise, alcohol or sexual habits

- to continue to improve the efficiency, effectiveness and quality of NHS care, and

- for Government or others, to take effective action on behalf of the community as a whole, to monitor and, when necessary, to eliminate or minimise the threats to individuals from the external world which they cannot themselves control.

FACING THE CHALLENGES: OPPORTUNITIES AND CONSTRAINTS

8 There are new opportunities as well as existing strengths on which to build. The reforms to the NHS – "Working for Patients", "Promoting Better Health" and "Caring for People" – have made profound changes:

- The more strategic – "health" – role of health authorities. The emphasis is first on assessing the state of health of the people they serve, second taking action and, third, assessing what improvements to health have been made.

- The new emphasis on health promotion in primary care.

- The renewed emphasis on the strategic responsibility of the Department of Health to monitor and assess the health of the nation and take the action necessary, or ensure the action is taken – whether through the NHS or otherwise – to improve and protect health.

- Renewed emphasis at all levels on developing better ways of monitoring and assessing health, and measuring the effectiveness of interventions and monitoring their achievement.

- The full integration of the Health Education Authority within the NHS.

9 These changes enable the NHS and the Department of Health better to play a leading role in addressing health issues. They reinforce the already well-developed mechanisms at both national and local level, in Government and outside, whereby key environmental and other health issues are addressed. The document sets out the responsibilities for health of Government Departments and local authorities and acknowledges the vital contribution of the voluntary sector and the increasingly important role of employers and employees' organisations.

10 Constraints are twofold: knowledge and resources.

- There is a need both to concentrate on what is known to be likely to be effective and recognise there are no simple, single solutions.

- The resources which are devoted to health care will always be finite in terms of available funding and the time, skills and enthusiasm of those involved in it. A health strategy needs to take this into account by setting and re-ordering priorities to make the best use of those resources.

11 A strategy is about developing a continuing process which provides opportunity for decisions

to be taken about what matters most, and allows attention to be concentrated on securing improvements in these areas.

A HEALTH STRATEGY FOR ENGLAND: FORM AND CONTENT

12 The proposed approach is:

First, to identify for attention key areas where improvements can be made.

Second, within those areas, to place the emphasis on securing genuine improvements in health for which targets can be set at either national or local level and progress monitored.

Third, to seek to improve knowledge and understanding in order to review and re-appraise priorities over time and bring further areas within the scope of national priorities and targets.

13 The document proposes three criteria for the selection of these key areas:

***First*, the area should be a major cause of premature death or avoidable ill-health (sickness and/or disability) either in the population as a whole or amongst specific groups of people**

and

***Second*, the area should be one where effective interventions are possible, offering significant scope for improvement in health**

and

***Third*, it should be possible to set objectives and targets in the chosen area and monitor progress towards achievement through indicators.**

OBJECTIVES AND TARGETS

14 Rigorous analysis of the possible interventions in each area and the setting of objectives and targets are essential disciplines for achieving a strategy. Targets should:

- provide an overall goal and sense of purpose
- be explicit, quantified and monitorable over time through appropriate indicators
- be achievable over a specified time, given what is known of scope for improvements within resource and other limitations, and within the wider context
- be challenging, if they are to help gain the maximum benefit from a strategic approach.

15 Ideally, these targets should be expressed as improvements in health or changes to risk factors (such as smoking) or the precursors of ill-health (such as raised blood pressure), though in some cases it may be appropriate to relate targets to interventions or processes which are known to improve health.

SUGGESTED KEY AREAS AND TARGETS

16 The document looks in turn at each of the three criteria for selecting key areas. The areas which emerge reflect a diversity of possible candidates:

causes of substantial mortality

- coronary heart disease
- stroke
- cancers
- accidents

causes of substantial ill-health

- mental health
- diabetes
- asthma

factors which contribute to mortality, ill-health and healthy living

- smoking
- diet and alcohol
- physical exercise

areas where there is clear scope for improvement

- health of pregnant women, infants and children
- rehabilitation services for people with a physical disability
- environmental quality

areas where there is a great potential for harm

- HIV/AIDS
- other communicable diseases
- food safety.

17 Annexes discuss each of these areas, together with possible targets (if any) which might be set. In some cases it concludes that target setting at this stage is neither possible nor helpful. Subject to the results of consultation the intention is to agree a limited portfolio of initial key areas and targets. Chapter 6 suggests the candidates for inclusion.

18 Other areas would be identified over time. The document recognises the importance of continued developments in each individual subject area and also in the general ability to monitor and assess the health of the population, develop and assess effective interventions and increase understanding of the measurement of health outcomes. Initiatives in all these areas are outlined, including the recently announced research and development strategy designed to provide a sound scientific basis on which to improve health.

MAKING PROGRESS: MAIN RESPONSIBILITIES

19 Achievement of improvements in health requires a shared commitment from all those with responsibilities for health – from Government to each individual. The need for concerted action calls for Government involvement in ensuring progress is made – it needs to lead, facilitate and monitor.

THE PARTICULAR ROLE OF THE NHS

20 The document considers the particular role of the NHS in achieving national targets. It stresses

the need to make the link between national priorities and local action which must be determined in the light of local circumstances and other local priorities.

21 The document sets out for discussion the ways in which national targets could be built into NHS planning mechanisms at local level, and sketches the individual roles of Regional Health Authorities, Family Health Services Authorities, District Health Authorities, and provider units. It also looks at the special role of the Health Education Authority.

QUALITY

22 The proposals focus primarily on improving health in terms of the incidence, prevalence and effects of disease. The document emphasises that this necessary refocusing of activity on the prevention of disease and the promotion of good health must *not* be at the expense of NHS treatment and care services. A better balance is needed, not a bias in one or other direction. To help ensure this balance is sustained in this health strategy the document proposes that in addition to the objectives and targets proposed each Health Authority set itself stringent "quality of service" targets. The Government believes the areas where targets should be set and the targets themselves are generally best decided at local level (with Government ensuring they are both rigorous and met) – with the exception that *appointment times* is an area where all health authorities *must* set targets. The NHS Policy Board will keep a close watch as these are developed.

CONSULTATION

23 The Government wishes to encourage full and widespread discussion of the idea of a health strategy for England. The main questions for consultation are identified in chapter 11.

24 During consultation three expert working groups will be established to look at issues raised in the document. One will be a group on the Government's role, including the wider public and political dimensions, health education, the role of the media and of industry and commerce. A second will cover the public health issues the strategy needs to address and will oversee work on specific options for objectives and targets. A third group will consider implementation within the NHS. The exercise will be overseen by an English Health Strategy Steering Group chaired by the Secretary of State for Health. There will also be a number of conferences.

THE HEALTH OF THE NATION

Notes:

i It has not been considered appropriate to provide detailed references to the various statistics quoted in this document (although where graphs or charts are used, sources are quoted). Most of the statistics for England have, however, been obtained from OPCS, and WHO for international comparisons. References to research findings, and other references, are treated similarly.

ii Where possible England-only statistics have been used. In some cases, however, information is available only for England and Wales, Great Britain, or the UK as a whole.

INTRODUCTION

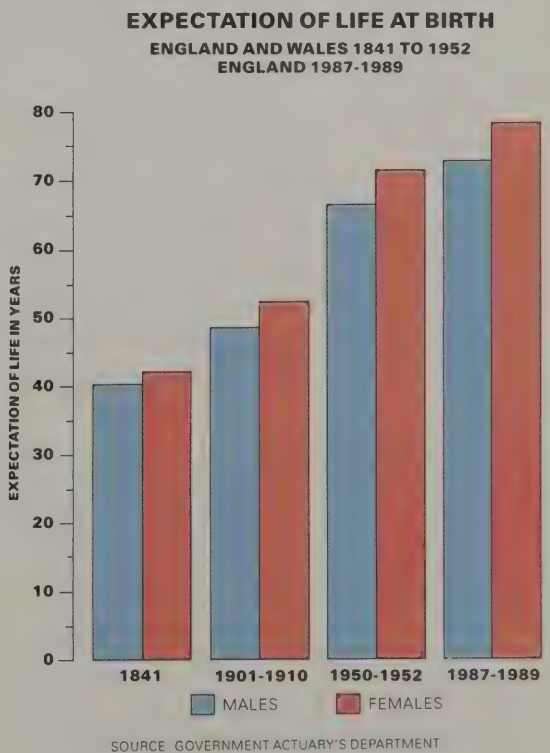
The achievements of the last 100 years – The scope for improvement – A strategic approach needed.

"Nasty, brutish and short". It is salutary to remember that it is only relatively recently – a matter of a few generations – that Thomas Hobbes' words ceased to be the common experience of life for the majority of people in England. A century ago four out of ten babies did not survive to adulthood. Life expectancy at birth was only 44 years for boys and 47 for girls. As recently as the early 1930s, 2500 women a year died during pregnancy or childbirth.

1.2 The transformation, illustrated in *figures 1 and 2*, has been profound. Life expectancy at birth is now 73 years for boys and 78 for girls. Infant mortality – a basic indicator of any nation's health – now stands (1989) at 8.4 deaths for every 1000 live births. During the second half of the 19th and the first half of the 20th centuries death rates from diseases such as tuberculosis, enteric fever, diphtheria, scarlet fever, whooping cough and measles fell to one per cent of their previous levels. Immunisation and the development of effective drug treatments played their part, but the achievement was essentially due to various social and public health changes. Safe water and sewerage, better housing, less overcrowding and better working conditions, greater economic prosperity, more effective methods of family planning, better nutrition and better education lay at the heart of the transformation.

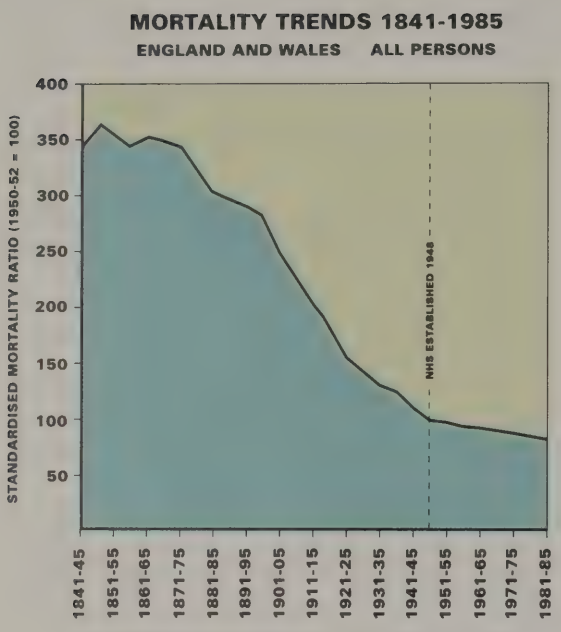
1.3 But major health problems remain. People may be living longer but many still die prematurely or have the quality of their lives – especially in their later years – impaired by avoidable ill-health.

1.4 The NHS reforms have created significant opportunities – particularly in the change of emphasis in the role of health authorities[1] – for addressing these problems. The Government believes that the time is now right to take a strategic approach to improving health; what



SOURCE GOVERNMENT ACTUARY'S DEPARTMENT

figure 1



THE STANDARDISED MORTALITY RATIO (SMR) IS AN INDEX WHICH ALLOWS FOR DIFFERENCES IN AGE STRUCTURE. VALUES ABOVE 100 INDICATE HIGHER MORTALITY THAN IN 1950-52 AND VALUES BELOW 100 INDICATE LOWER MORTALITY.

SOURCE OPCS

figure 2

needs to be done can best be secured by concerted action within a common strategic framework.

1.5 This consultation document sets out for discussion and comment what the Government hopes to achieve through the development of such a health strategy for England. The over-riding aim is that the strategy should genuinely contribute to improvements in people's health by focusing attention and action on the major health problems to be tackled for the rest of this decade and beyond into the 21st century.

1.6 This document deals only with England. Separate approaches have been taken in Wales, Scotland and Northern Ireland.

[1]Unless otherwise stated, the term 'health authorities' used in this document refers to Regional Health Authorities, District Health Authorities, Family Health Services Authorities and, where appropriate, Special Health Authorities.

WHY A STRATEGY FOR HEALTH?

Why a strategy is needed – Rectifying the balance between health care and health – Turning aspirations on health promotion and disease prevention into reality – The pioneering work of the World Health Organisation's "Health for All" – An English Strategy – Common ownership – The broad principles and objectives – The importance of objectives and targets for health.

It is commonplace to say of health services, in other countries as much as England, that they are not **health** services but rather treatment and care services. The major preoccupation is with treating illness and looking after infirm, chronically sick and elderly people who need continuing care and support.

2.2 It is not difficult to understand the reasons for this. People fall ill and need to be treated and cared for. By contrast, the promotion of good health is not so immediately demanding. Nor is understanding of how effectively to promote health as advanced as understanding of how to treat illness.

2.3 Even within the treatment and care services themselves the emphasis in measuring achievement has tended to be on the volume of resources put into the service and the numbers of patients treated rather than what improvements to health and quality of life have been achieved.

2.4 The need for countries to re-orient their policies and programmes towards health rather than simply health care was behind the World Health Organisation's "Health for All by the Year 2000" programme. The HFA approach has been adopted by some countries as the basis for developing their own health strategies. It has similarly been used by many health authorities in England. The Government acknowledges its debt to WHO – and the extent of that debt will be clear from this document – but as WHO is the first to acknowledge, HFA cannot in itself provide any country with a strategy tailored to its specific needs. Valuable lessons can be learned from WHO and other countries' experience. But England is no exception to the rule that every country needs its own approach – one which is accepted by the general population.

A STRATEGY FOR HEALTH

2.5 The aim of a strategy is simple: it is to improve the span of healthy life. The value of a strategy lies is identifying broad aims, clarifying objectives and responsibilities, focusing concerted action and setting a framework against which such improvement can be measured.

2.6 A number of key strategic policy objectives and guiding principles underpin the entire approach. They are the need:

- to identify the **main health problems** and focus on them;
- to focus as much on the **promotion of good health and the prevention of disease** as on treatment, care and rehabilitation, **whilst**

ensuring that work on either is not at the expense of the other;

• to recognise that as health is determined by a whole range of influences – from genetic inheritance, through personal behaviour, family and social circumstances to the physical and social environment – so **opportunities and responsibilities** for action to improve health are widely spread from individuals to Government;

• to recognise that the concerted action needed calls for **greater co-operation** between those involved, at national and local level, within and outside the NHS;

• to secure a proper balance between central strategic direction and **local and individual discretion, flexibility and initiative;** and ensure that where responsibilities are devolved there is fair, but rigorous, scrutiny of performance and outcomes;

• to secure the best possible use of available **resources** – resources have grown considerably in recent years but they will always be finite. There are competing demands in society for expenditure by the Government. Making the best use of resources – money and people – is therefore an important objective.

2.7 Achievement of these strategic policy objectives in turn means:

• improving the ability to **monitor** the state of the people's health, **evaluate** the health benefits of policies and programmes, and **assess the effectiveness** – in terms of 'health gains' – of particular services and practices;

• ensuring everyone has the best possible **information** needed to understand the influences on health, especially the influence of behaviour, and the necessary **support** to improve health;

• **involving people more** at both strategic and operational levels in discussion and decisions about options and priorities.

2.8 To achieve these ends the Government believes that clear objectives and specific targets are central to a health strategy. These give a common sense of direction and purpose and a tangible result at which to aim, and stimulate the development of the ability to assess, compare and contrast performance. They also provide a measure by which to decide action and use of resources and by which to judge success. They lie at the heart of what this document proposes.

THE CHALLENGES

The challenges – Longevity increased, but quality of extra years uncertain – Large remaining burden of preventable death and illness – Quality of health care uneven – Addressing the causes – NHS alone cannot solve the problems – Individual behaviour: informed choice, education and opportunity – External threats to health – Continued development of NHS services – The challenge of medical advance and demographic change.

Chapter 1 highlighted the transformation in the health of the people of England. Vigilance is needed to maintain the improvements. Safe water and effective disposal of waste, the supply of wholesome food, safety at work, controls on pollution and good housing remain as important as ever.

3.2 If the ideal is for each person to lead a physically and mentally healthy life well into old age then, although the health of the people of England is generally very good:

- many people still die prematurely or suffer debilitating ill-health from conditions – diseases, accidents – which are to a large extent preventable;
- many of these causes of death and ill-health are known to be preventable;
- there are significant variations in health – geographical, ethnic, social and occupational – within England as in other countries;
- despite significant progress – and what the NHS has achieved is formidable – there are still marked variations in the quantity and quality of health care in different parts of the country.

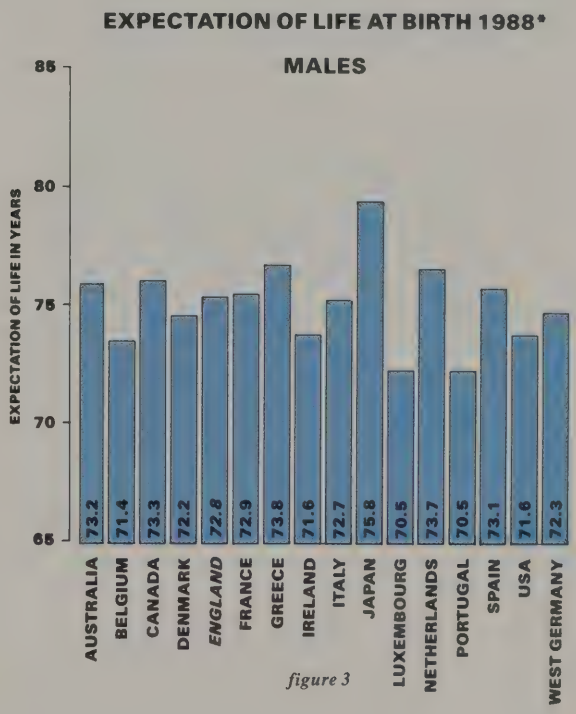


figure 3

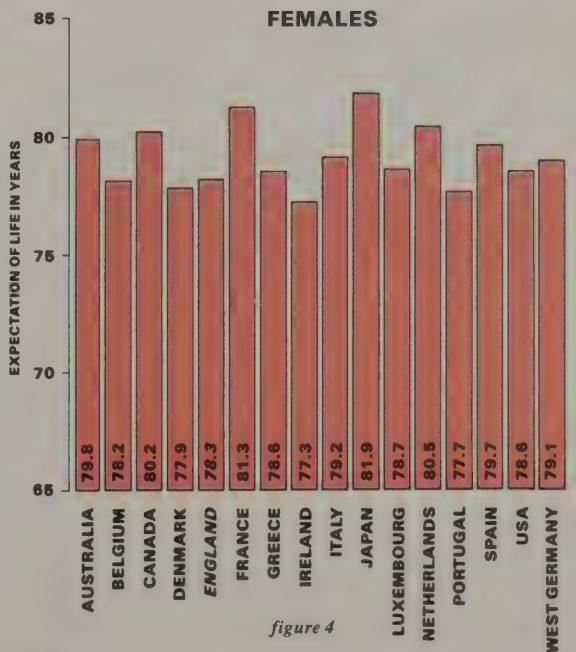
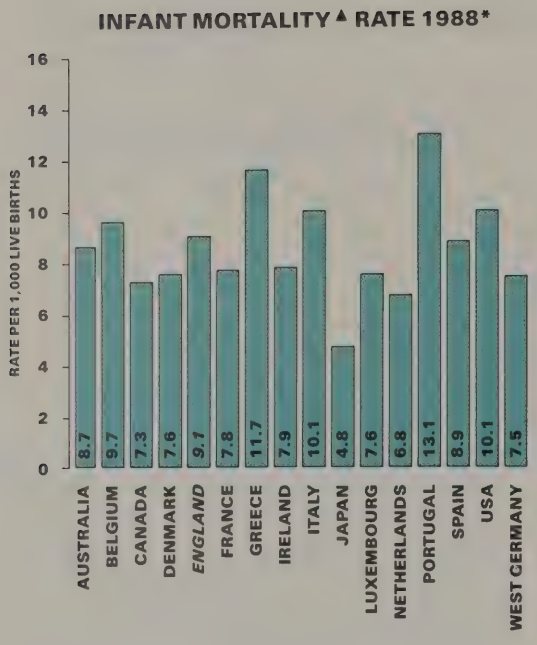


figure 4

*DATA FOR 1988 EXCEPT FOR GREECE, IRELAND, USA, CANADA AND AUSTRALIA 1987, BELGIUM AND ITALY 1986, AND SPAIN 1985

SOURCE OPCS, WHO ANNUAL, HFA INDICATORS



▲ INFANT MORTALITY = DEATHS IN THE FIRST YEAR OF LIFE

*DATA FOR 1988 EXCEPT FOR GREECE, IRELAND, USA, CANADA, JAPAN AND AUSTRALIA 1987, BELGIUM AND ITALY 1986, AND SPAIN 1985

SOURCE: OPCS, WHO ANNUAL, HFA INDICATORS

Figure 5

THE FACTS

3.3 *Figures 3 and 4* show life expectancy at birth for men and women in various European Community and other western countries. Although the differences seem small, a shift of only one year represents much life gained or lost in the population as a whole.

Figure 5 shows the infant mortality rate and the variations between countries.

Figure 6 shows the distribution of total deaths by cause in 1931 and 1988. A marked change in the pattern of disease is evident. The proportion of deaths due to infective, genito-urinary and respiratory disease has declined but preventable diseases which have been significantly reduced have been replaced by other preventable diseases which have not. Between them coronary heart disease, cerebrovascular disease (stroke) and lung cancer account for about 36% of all premature deaths (death before age 65[1]) – some 37,000 deaths each year. Each is to a significant extent preventable.

Figure 7 shows years of life lost up to age 65 years. This form of presentation gives particular weight to deaths occurring at younger ages. (For this analysis, a death occurring at age 15 accounts for the loss of the 50 years of life between 15 and 65, whereas a death at age 60 years contributes a loss of only five years of life.) In males, although circulatory disease and cancer still contribute substantially to loss of years of life, other causes, such as accidents, become more prominent. In females, cancer – particularly cancer of the breast, cervix, uterus and ovary – is a major contributor to loss of life under 65 years.

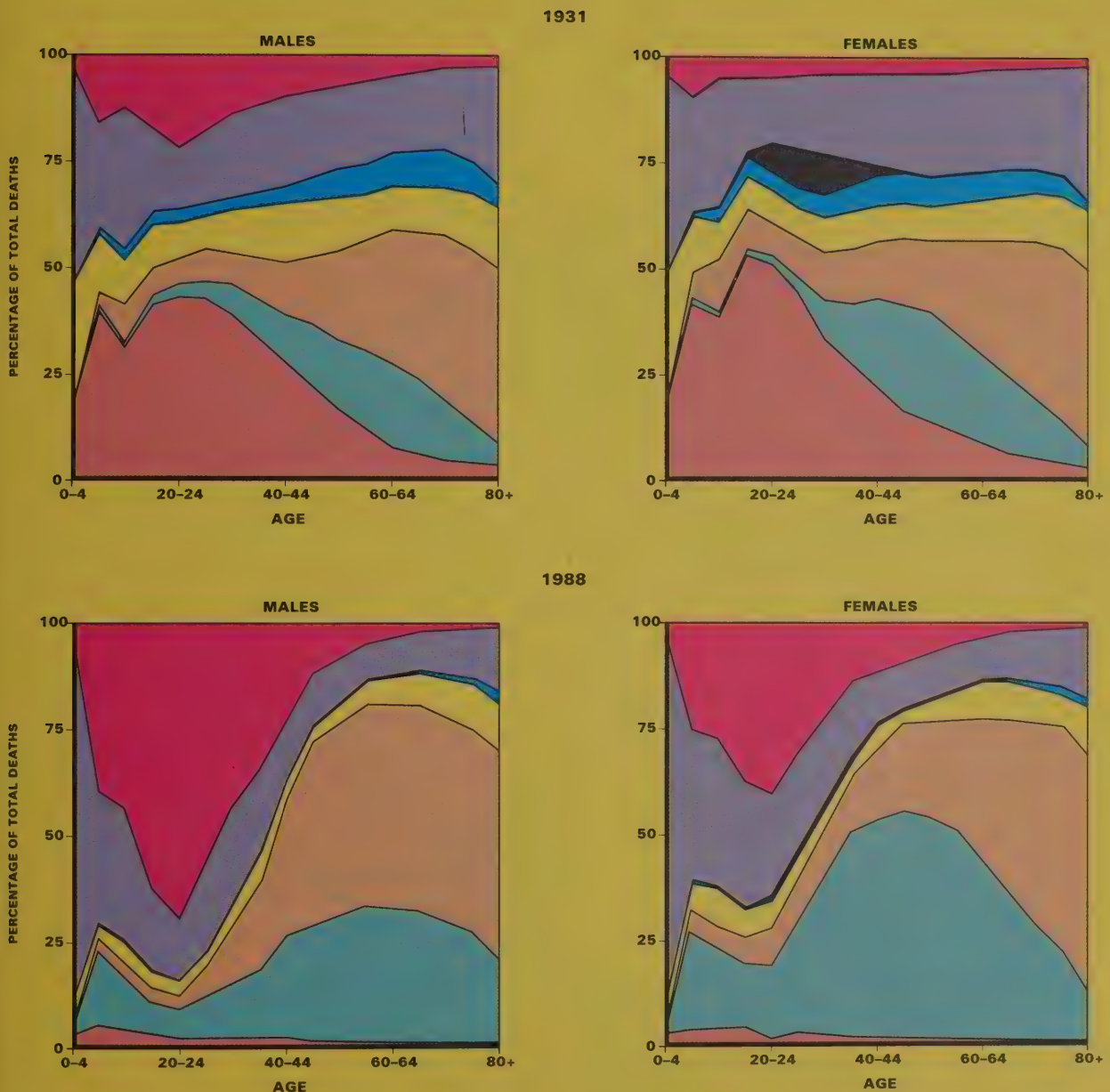
Figure 8 shows an upward trend in self-reported long-standing illness between 1972 and 1989 (GB data). What does it mean? A population more conscious of its ailments? Or better treatments leading more people to go to their GP?

Figure 9 shows trends in infant mortality by social class. All rates are declining but the differences persist, showing the scope for

[1] The definition of premature death as death before the age of 65 is a convention used by many countries. It provides a common statistical basis; its use in this document is not to be taken as meaning that deaths after age 65 may not also be premature.

DISTRIBUTION OF TOTAL DEATHS BY CAUSE AND AGE

ENGLAND AND WALES 1931 AND 1988



SOURCE, REGISTAR GENERAL'S ANNUAL REPORT 1931
OPCS MORTALITY STATISTICS 1988

figure 6

DISTRIBUTION OF YEARS OF LIFE LOST UP TO AGE 65 YEARS*
BY CAUSE OF DEATH
ENGLAND AND WALES 1988

MALES

FEMALES

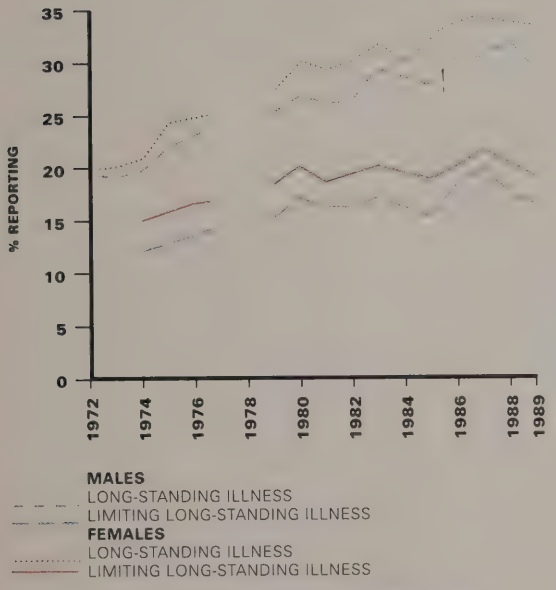
*DEATHS UNDER 28 DAYS EXCLUDED.

SOURCE OPCS

figure 7

TRENDS IN SELF-REPORTED LONG-STANDING ILLNESS

GREAT BRITAIN 1972-1989*

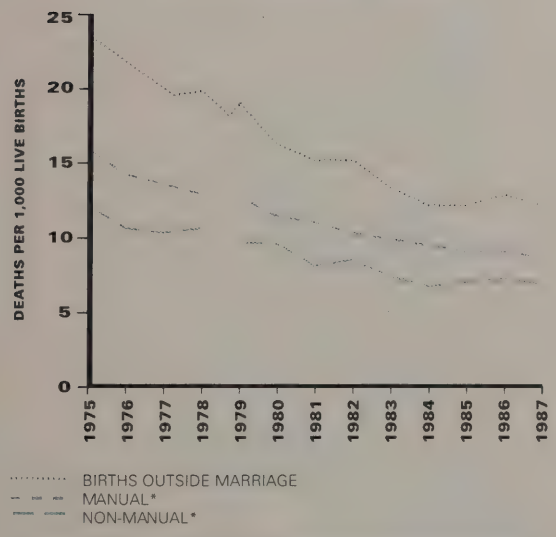


*DATA NOT AVAILABLE FOR 1977 AND 1978
SOURCE: GENERAL HOUSEHOLD SURVEY

figure 8

TRENDS IN INFANT DEATH BY SOCIAL CLASS*

ENGLAND AND WALES 1975-1987



*SOCIAL CLASS OF BIRTHS WITHIN MARRIAGE AS DEFINED BY OCCUPATION OF FATHER:
A NEW CLASSIFICATION WAS USED FROM 1979 ONWARDS
SOURCE: OPCS (DH3 SERIES)

figure 9

further improvement. These variations in health persist here, as in other countries. The mortality rate for men aged 15-64 in manual groups is about 1.5 times the corresponding level for non-manual groups.

Figure 10 shows mortality from coronary heart disease at ages 35–64. This longstanding pattern is striking and the reasons are not fully understood. Amongst men, there is a threefold variation between the areas with the highest and lowest death rates.

Figure 11 shows the variations within England in mortality from cancer of the cervix, mortality which is largely preventable.

ACTION

3.4 There are some common themes for action to secure better health.

- There is a need to improve monitoring and understanding.

- The NHS alone cannot address or solve all problems. It has a key role to play, but action is required on a broader front.

- Exposure to risks – from people's own behaviour or from the physical and social environment in which they live and work – which are inimical to health, needs to be reduced.

- On behaviour – lifestyles – a balance of action is needed. People cannot be forced to behave sensibly in terms of their smoking, eating, exercise, alcohol or personal sexual habits. But efforts can be made to ensure that when they choose, they are exercising informed

DEATHS FROM CORONARY HEART DISEASE 1989

ENGLAND ALL PERSONS AGED 35-64

STANDARDISED MORTALITY RATIOS (ENGLAND AND WALES = 100)

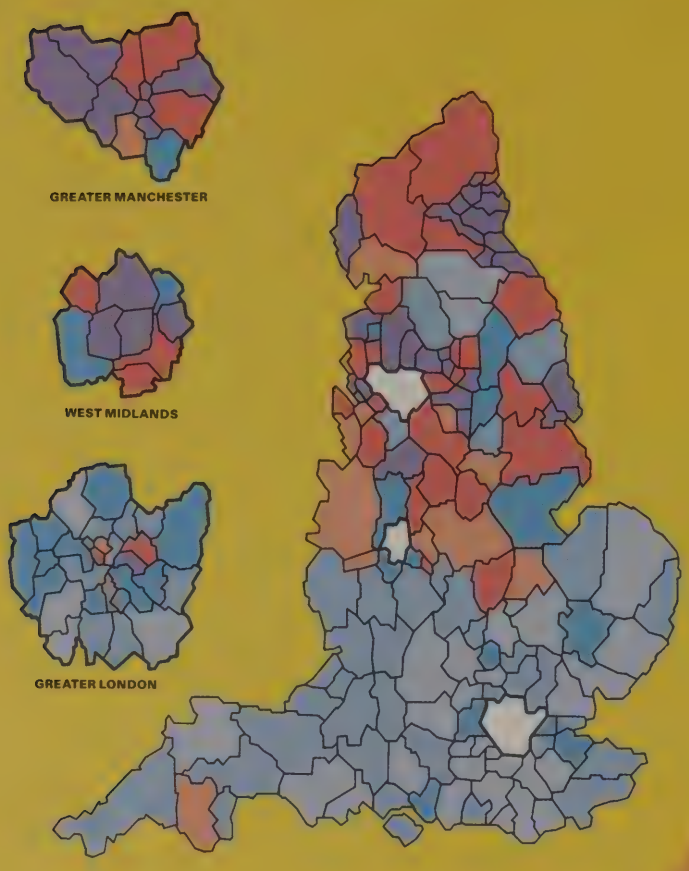


figure 10

DEATHS FROM CANCER OF THE CERVIX 1985-19

ENGLAND FEMALES AGED 15-64

STANDARDISED MORTALITY RATIOS (ENGLAND AND WALES = 100)

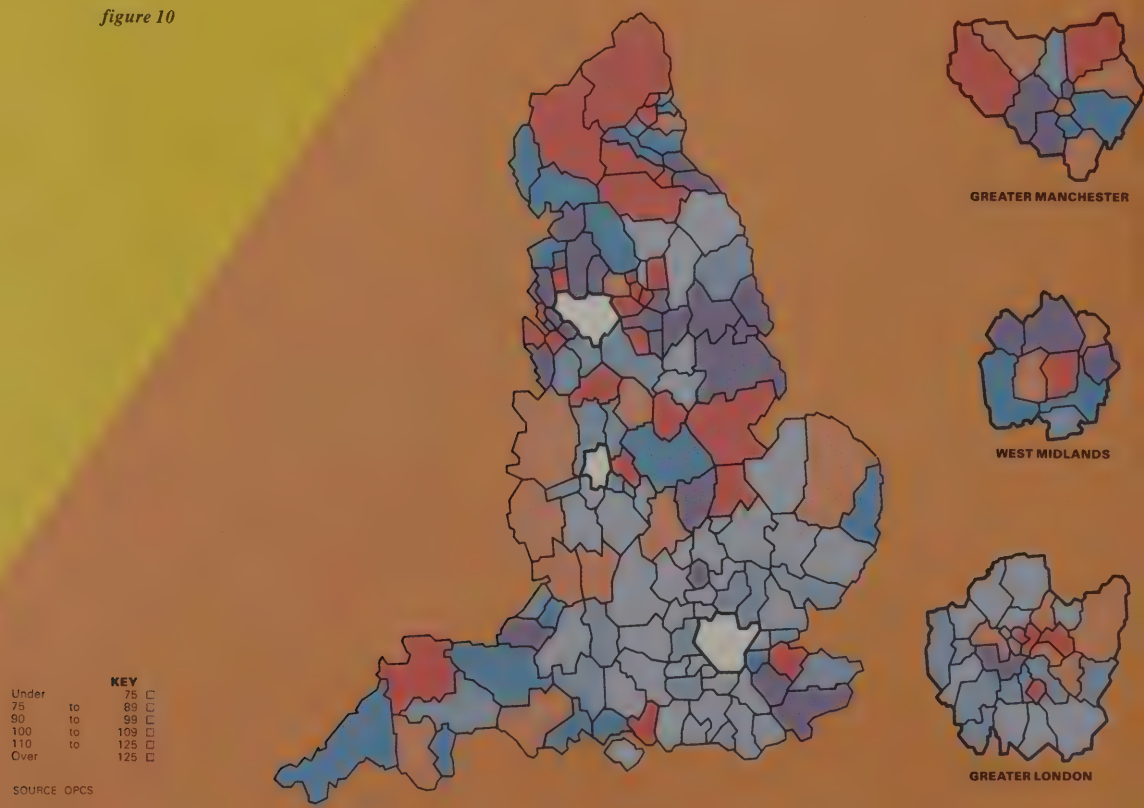


figure 11

VALUES ABOVE 100 INDICATE HIGHER MORTALITY THAN THE ENGLAND AND WALES AVERAGE.
VALUES BELOW 100 INDICATE LOWER MORTALITY.

choice in circumstances where this is possible.

• On threats to individuals from the external world over which people have little or no control it is the responsibility of Government, or others, to take effective action on behalf of the community as a whole.

• There is a need to ensure that the final measure of achievement both for treatment and prevention is the health outcome, ie how health has been improved. For example, some forms of treatment may not have an effective outcome. This means they could take resources away from procedures which have successful outcomes.

3.5 The following figures show where action has been successful and where further action is necessary.

SOURCE DH, DATA SHOWN AFTER DOTED LINE ARE PROVIDED FROM THE COVER PROGRAMME AND ARE NOT DIRECTLY COMPARABLE WITH THOSE FROM EARLIER YEARS

figure 12

Figure 12 shows a major NHS achievement in respect of immunisation.

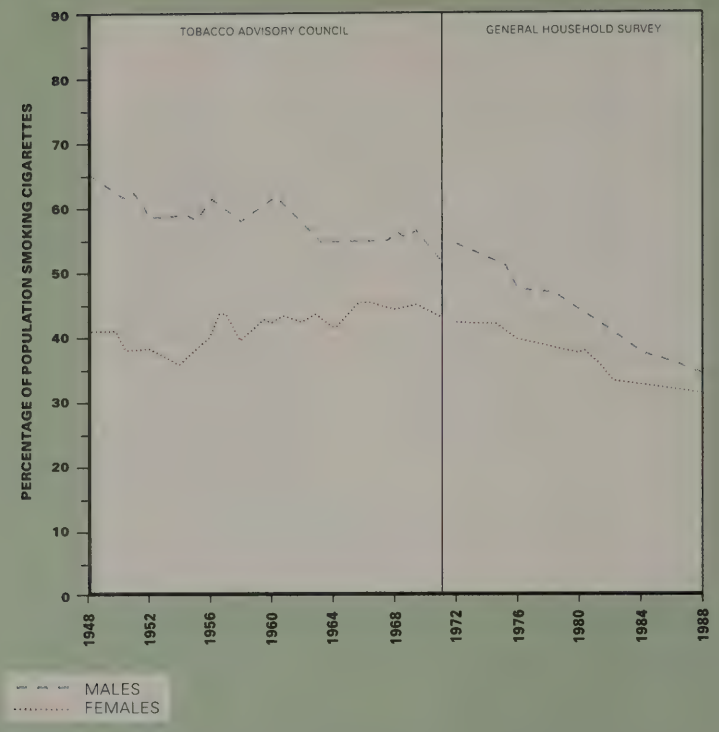
Figure 13 shows a significant fall in cigarette consumption. However, 32% of the population still smoke cigarettes. This is despite the clear evidence – and public awareness – that cigarette smoking causes about 30% of all cancer deaths (some 29,000 deaths a year through lung cancer alone) and is a significant contributor to coronary heart disease, chronic respiratory disease and other diseases.

Figure 14 shows that, despite considerable health education activity, the last 10 years has seen virtually no change in the average contribution made by fat to energy derived from food: it has remained at about 42% compared to the maximum intake of 35% recommended by the Committee on Medical Aspects of Food Policy (COMA). However, consumption of saturated fatty acids has declined from 19% of food energy in 1980 to 17% of food energy in 1989, compared with a recommended maximum of 15%.

Figure 15 – between 1980 and 1987 the proportion of adults aged 16-64 in Great Britain overweight or obese increased from 39% to 45% of men and from 32% to 36% of women.

Figure 16 – in 1986/87 only about one third of the adult British population aged 18-64 had serum cholesterol levels in the desirable range (less than 5.2 mmol/l); 6% of men and 8% of women had severely elevated levels (7.8 mmol/l or more).

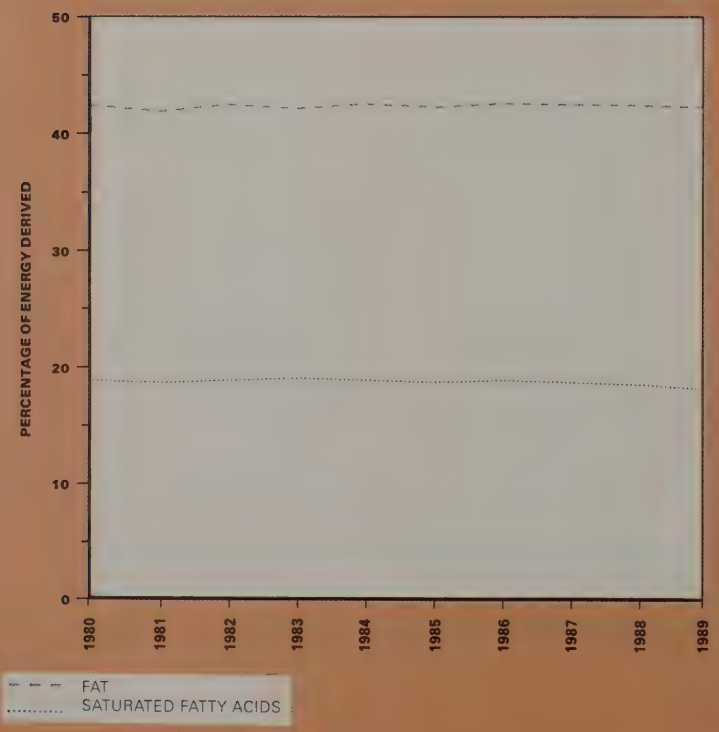
PERCENTAGE OF CIGARETTE SMOKERS IN THE POPULATION
PERSONS AGED 16 AND OVER GREAT BRITAIN 1948-1988



SOURCE: TOBACCO ADVISORY COUNCIL & GHS. THE STATISTICS FROM THESE TWO SOURCES ARE NOT ON EXACTLY THE SAME BASIS.

figure 13

TRENDS IN CONSUMPTION OF FAT AND SATURATES
GREAT BRITAIN 1980-1989

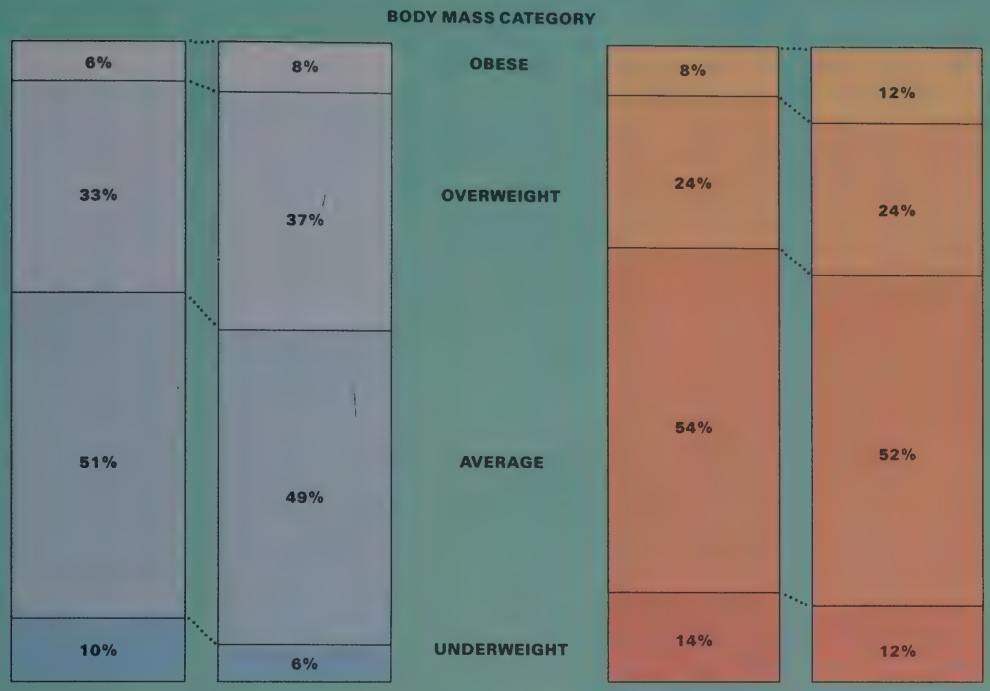


SOURCE: MINISTRY OF AGRICULTURE, FISHERIES AND FOOD

figure 14

PERCENTAGE DISTRIBUTION OF ADULTS BY BODY MASS*

AGES 16 - 64 YEARS GREAT BRITAIN - 1980 AND 1986-87



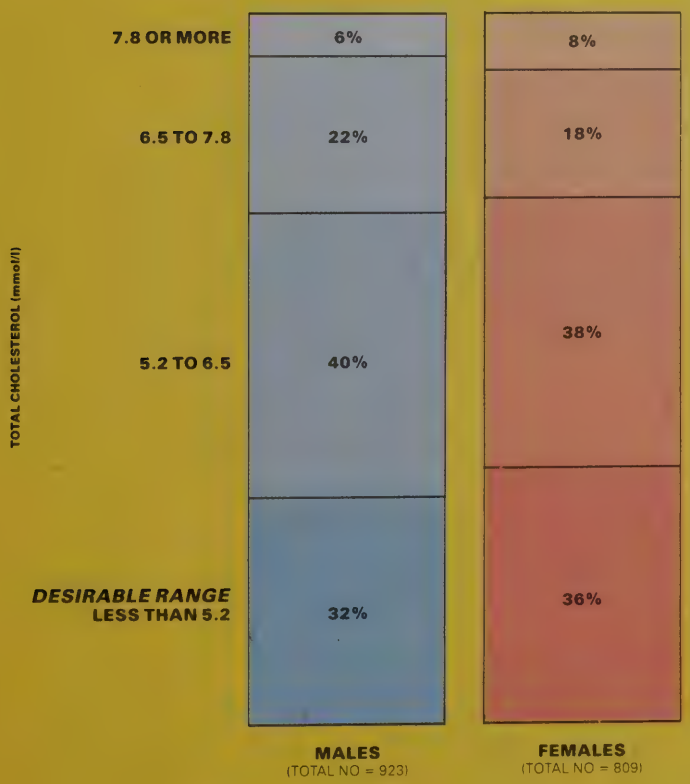
*BODY MASS INDEX = $\frac{\text{WEIGHT}}{\text{HEIGHT}^2}$

SOURCE: THE DIETARY AND NUTRITIONAL SURVEYS OF BRITISH ADULTS (OPCS)

figure 15

PERCENTAGE DISTRIBUTION OF TOTAL SERUM CHOLESTEROL

AGES 18 - 64 GREAT BRITAIN - 1986-7



SOURCE: THE DIETARY AND NUTRITIONAL SURVEYS OF BRITISH ADULTS (OPCS)

figure 16

Figure 17 illustrates the relationship between alcohol consumption, deaths from chronic liver disease and the affordability of alcohol. 1.4 million people are classified as 'heavy drinkers'. Alcohol is also a major cause of accidents: about 20% of drivers and riders killed in road traffic accidents (in GB) have blood alcohol levels over the legal limit.

3.6 These new challenges are not the only ones. Redressing the imbalance between health promotion and prevention of ill-health and treatment and care must not lead to a new imbalance. There is a continued need to improve further the quality of care and treatment. Waiting times remain a formidable challenge. There is, too, the ever-present challenge posed by new medical advances. Above all there is the need to maintain the quality of care and support for chronically sick people, elderly infirm people, mentally ill and handicapped people and those who are dying, in the face of some significant demographic changes. Between 1981 and 1989 the number of people aged 75-84 has risen by 16%, and those 85 and over by 39%. *Figure 18* shows how this growth will continue. Much of what this document says about prevention of heart disease, stroke and cancers is especially relevant to this growing number of elderly people. This is where the burden of avoidable ill-health finally falls. The Government recognises, moreover, that success in reducing premature mortality will increase the number of elderly people and so, unless a healthier old age accompanies greater longevity, lead to a greater demand for services. That is why the emphasis must be as much on quality of life as on quantity of life.

ALCOHOL CONSUMPTION, AFFORDABILITY AND DEATHS FROM CHRONIC LIVER DISEASE

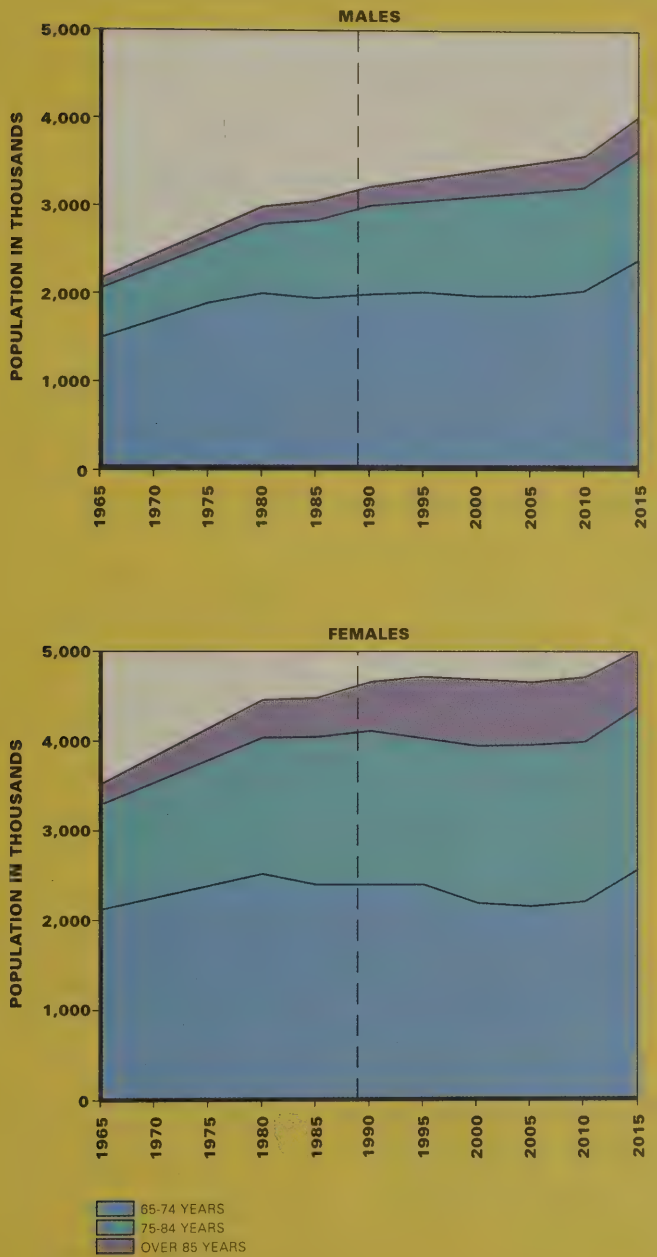
UNITED KINGDOM 1965-1989

SOURCES
1 OPCS – NOT ALL THESE DEATHS WERE DUE TO ALCOHOL. DISCONTINUITY BETWEEN YEARS 1978 & 1979 DUE TO CHANGE IN CODING
2 ECONOMIC ADVISORS OFFICE, DEPARTMENT OF HEALTH
(AFFORDABILITY = PERSONAL DISPOSABLE INCOME/PRICE OF ALCOHOL)
3 CUSTOMS AND EXCISE WITH DEPARTMENT OF HEALTH

figure 17

ELDERLY POPULATION: AGE GROUP TRENDS

ENGLAND AND WALES 1965-2015



DATA FROM 1990 ARE POPULATION PROJECTIONS BASED ON REGISTRAR GENERAL'S MID 1987 ESTIMATES
SOURCE: OPCS

figure 18

Facing the Challenges: Opportunities, Strengths and Constraints

New opportunities: The reformed NHS – Strategic role for Health Authorities – Assessment of the state of the population's health – Re-focusing of Department of Health on broader public health issues – Existing strengths: The Wider Government Role – Local Authorities – Industry and Commerce – The Voluntary Sector – Shared commitment – Constraints: Knowledge and Resources.

New opportunities on which a strategy can build are twofold.

First, within the NHS the reforms have prepared the ground for a more strategic approach.

Second, within the Department of Health itself, less involvement in day-to-day NHS service management allows a renewed emphasis on wider health issues.

THE NHS

4.2 While the NHS is not the only vehicle for improving health, it has a key role, one which has been significantly enhanced over the last two years. From being preoccupied with the provision of health services, Health Authorities have now taken on a more strategic – "health" – role. Their job is to:

- assess the state of health of the people they serve;
- assess what needs to be done to improve health;
- set priorities for those improvements;
- purchase effective services to meet these needs;
- stimulate and inform discussion of action needed at local level to address the wider issues of health;
- work in co-operation with each other and with other local agencies in taking effective action on threats to health;
- assess the effect of policies and programmes against the key criterion "has health improved?"

4.3 The initial assessment of the state of health and what is likely to prove an effective use of resources to improve health is the cornerstone. Central to this task are the newly appointed Directors of Public Health and the requirement on them to produce independent annual reports on the state of public health.

4.4 This change of role, together with the emphasis on health promotion in the new contracts for general practitioners and Regional Health Authorities' taking on responsibility for managing Family Health Services Authorities, will facilitate concerted and co-ordinated NHS action on local health problems. Central also is the emphasis clinicians themselves have placed on the need for the rigorous assessment of the effectiveness of what is done – in terms of benefit both to individuals and the population as a whole.

THE DEPARTMENT OF HEALTH

4.5 The strategic role of the Department of Health is to monitor and assess the health of the nation and take the action necessary, or ensure the action is taken – whether through the NHS or otherwise – to improve and protect health. The creation of the NHS Management Executive, providing a more strategic 'head office' function for the NHS, allows the Department of Health as a whole to re-emphasise that this responsibilty goes wider than the NHS.

4.6 The major central functions on which a strategy for health can be developed are:

- monitoring and assessing the state of the population's health and improving the methods for such monitoring and assessment;

- through research, assessing (or stimulating the assessment of) the effectiveness of steps taken to improve health, whether these are aimed at the popluation as a whole, or at particular groups within it, or are treatments for specific diseases;

- deciding on priorities, policies and programmes in the light of such assessments and taking action, or where responsibilities lie elsewhere, arguing the case for action.

THE WIDE RANGE OF HEALTH-RELATED ACTIVITY

4.7 These changes build on the NHS's strengths – a highly dedicated and professional workforce, its rational and highly developed primary, secondary and tertiary system of treatment and care, and a rational and cost-effective system of funding and management of the health care system as a whole. The strategy can also build on well developed systems for:

- protecting the public from hazards to health – environmental and industrial hazards, food, air and water safety of consumer products;

- maintaining family, community and other social and economic structures conducive to the maintenance of the health of the individual and the population;

- providing general education and information to people to help them maintain their health as well as very specific information about, and support for, people with particular diseases or disabilities.

4.8 Responsibilities in all three areas fall variously throughout national and local government and the voluntary and industrial and business sectors.

4.9 Within central Government, the range of relevant responsibilities is extensive and includes:

- the **Department of the Environment's** general responsibility for all aspects of environmental quality and protection, housing, and inner cities;

• the **Department of Transport's** responsibility for road safety and other forms of transport;

• Action taken by the **Chancellor of the Exchequer** in his Budget which affect excise duties on alcohol, tobacco and petrol;

• the **Home Office's** responsibility for action on illegal drugs, misuse of alcohol and fire safety;

• the **Ministry of Agriculture, Fisheries and Food's** responsibility, shared with the Department of Health, to ensure food is safe for general consumption and that consumers have the information they need to choose a healthy and wholesome diet;

• the **Department of Education and Science's** responsibility to support a curriculum for all maintained schools which promotes the sound spirtual, moral, cultural, mental and physical development of its pupils and of society, and adequately prepares pupils for adult life – health education in schools and sport in both schools and adult life are especially relevant as is DES's funding of medical research via the Medical Research Council;

• the **Department of Social Security's** responsibility for efficient and effective delivery of social security benefits totalling more than £60 billion a year;

• the **Department of Trade and Industry's** responsibility for raising public awareness about potential hazards in and around the home;

• the **Department of Energy's** responsibility for health and safety in the nuclear industry and also for the safe installation and use of electricity suppliers' lines and apparatus;

• the **Employment Department's** responsibility, through its Employment Rehabilitation Service, for assisting people with disabilities and long term health problems who wish to identify appropriate work and prepare for it;

• the **Health and Safety Commission and Executive's** responsibilities for health and safety in the workplace, and for the protection of the public from harmful consequences of work activities.

4.10 The spread of responsibilities offers an opportunity because it means a shared interest in health amongst Departments; and a challenge because of the need to ensure policies and programmes are developed with action taken on a concerted basis across Departmental boundaries.

4.11 In addition to central Government, local government, industry and commerce and the voluntary sector have well established roles:

• **Local government** influences the general environment through planning, housing, and transport functions. It protects the public and workpeople from hazards and dangers through Environmental Health Departments and Trading Standards Officers, as well as through the fire and police services. It can contribute to opportunities for health promotion through provision of recreation and sporting facilities, and through its own information services (eg libraries). It has also responsibility for the provision of social services, and is to take on new responsibilities for care in the community.

• **Industry and commerce,** both as employers and producers, have responsibilities and opportunities for improving health. Not only must they provide a safe and healthy working environment, ensure that their products do not endanger the consumer and play their part in avoiding environmental pollution, but they also have considerable scope for investment in the health of their workforce by

- promoting healthy living, ensuring that catering services offer healthy options, or providing exercise facilities
- offering to employees the chance to participate in workplace health initiatives.

• **Voluntary sector** embraces organisations ranging from those providing care services, funding and supporting research, and self-help groups for patients to those dedicated to health education and campaigning, and provides an invaluable contribution to health.

4.12 These foundations provide a firm basis on which to foster a widespread shared commitment to better health and improve co-ordination and co-operation between all those involved. The strategy will build on them.

CONSTRAINTS

4.13 Constraints are twofold: knowledge and resources. Idealism needs to be tempered by recognition of the limitations of knowledge. While efforts must be made to try to extend knowledge and understanding, it is important to concentrate on what is likely to be effective given the present state of knowledge.

VARIATIONS

4.14 Tempering idealism with pragmatism is especially needed in relation to the challenge presented by the variations, noted in chapter 3, in the incidence of good health, illness and death. England like other developed countries, has wide variations between different parts of the country, different ethnic groups and different occupational and income groups:

• There is a variation of 3:1 between the districts with the highest and lowest death rates from coronary heart disease (for men 35-64 years);

• The mortality rate for men aged 20-64 in manual occupations is about 1.5 times the level for non-manual occupations;

• Conversely, the incidence of breast cancer in women is greater in social class I than in social class V;

• The death rate from coronary heart disease in those born in the Indian sub-continent is more than 30% higher in men and 40% higher in women than in the population as a whole. The prevalence of diabetes shows similary marked variations, while some diseases (eg sickle cell disease) affect particular ethnic groups.

4.15 The reasons for these variations are complex. The Government does not believe there is any panacea – here or elsewhere in the world – either in terms of a full explanation or a single action which will eradicate the problem. But neither difficulty is a reason for inertia. Progress can be made on three fronts:

• **first,** through the continued general pursuit of greater economic prosperity and social well-being;

- **second,** through trying to increase understanding of the variations, and the action which might effectively address them;

- **third,** through specific initiatives to address the health needs of particularly vulnerable groups, whether geographical, ethnic, occupational or others who need specific targeted help.

4.16 The reformed NHS offers significant opportunities for action on the second and third points. Central is the explicit role of health authorities in producing their assessments of the health and health care needs of their local populations, and better integration of the organisation and delivery of family, community and hospital services. The NHS is now better able to identify areas or groups where the highest rates of sickness occur, and direct resources to meet needs. In all these variations the Government believes the emphasis should be on disaggregation of the problems down to specific issues which can be targeted for effective action.

RESOURCES

4.17 When the NHS was first established there was a belief that, once the backlog of unmet need had been addressed, the service could satisfy the demand for health care without large or continuing increases in expenditure. The reasons this did not happen are various but the problem is primarily one of success, not failure. More and more illnesses lent themselves to treatment. Usually – not always – the direction was towards more expensive treatment. There was also the additional cost of providing for a longer lived population.

4.18 The resources devoted to the NHS have grown considerably since its formation. Over the past ten years expenditure in real terms on health has increased by almost half. However, in the face of society's other demands, it has to be recognised that the resources devoted to health will always be finite. Making the most efficient use of those resources is therefore a key area for the health service. The result is that choices have to be made and priorities set.

4.19 Development of a strategy for health raises the same question. As with health care services, priorities for the broader health issues need to be agreed, with resources – financial, time, skills and enthusiasm – concentrated to tackle priorities in a concerted way. Not everything can be tackled at once. Central to a strategy for health must be a rational approach to identifying the current major problems, assessing where action is most likely to be effective and concentrating resources on those problems.

4.20 This does not mean priorities, once set, are set for all time. New problems will arise when existing ones have been successfully addressed. A strategy for health will have succeeded if, in retrospect, it is judged that priority was given and energies devoted to what mattered most at the time. That is what this strategy seeks to do.

DEPARTMENT OF ENVIRONMENT

The Department of the Environment helps secure good health by improving the quality of the environment and seeking to ensure that a decent standard of affordable housing is available to all. It coordinates Government policy on environmental protection as set out in the White Paper "This Common Inheritance".

Health related action includes:

- **Environmental Protection Act 1990:** introduction of controls by HM Inspectorate of Pollution and local authority environmental health departments to minimise industrial pollution of air, water and land; enhanced noise and litter controls; improved waste disposal and recycling arrangements.

- **Water Act 1989:** establishment of Drinking Water Inspectorate to set and enforce standards for drinking water quality and of National Rivers Authority to control discharges of pollutants into water.

- **Housing:** over the century two million slums cleared and six million subsidised dwellings built; since 1960s two million grants given for home improvement. Nearly £2 billion a year now being spent on renovation to improve the condition of local authority housing; £500 million a year is given in grants – mainly to less well-off owner occupiers – to improve unsatisfactory private houses; the output of housing association subsidised homes is planned to almost double between 1989/90 and 1993/94; and short-term programmes aimed at 11,000 households temporarily housed in bed and breakfast accommodation, and the 3000-5000 people sleeping rough on the streets.

- **Inner cities:** because poor health is often linked to the economic, environmental and social problems in inner cities the Government's inner city policies which aim to improve living conditions will also raise general levels of health. The Urban Programme also funds health promotion and disease prevention, improvements to primary health care, services for homeless mentally ill people and access to health care for ethnic minorities.

- **Sewage treatment:** requirement (implementing EC Directive) to end significant discharges of untreated sewage to inland and coastal waters by 1998 and 2005 and to improve bathing waters.

- **Vehicle pollution:** tight new emission limits for cars and heavy diesels introduced.

- **Toxic metals:** action has reduced human exposure to lead (by, for example, limiting the lead content of drinking water, food, petrol and paint) and other toxic metals, particularly mercury and cadmium; blood lead levels are now half those of the mid-1970s.

- **Radon:** guidance now allows householders in highest risk areas to make informed decisions about risks; free testing of radon levels in affected areas available.

DEPARTMENT OF EDUCATION AND SCIENCE

The Department of Education and Science makes a significant contribution to health. The Government's policy is to encourage schools to equip their pupils with the knowledge, skills and attitudes they will need to make well-informed, independent judgements and to safeguard their long-term good health. Health education in schools lays the foundation for the individual's subsequent health-related behaviour and lifestyle; and sport makes an important contribution to individual health, both at school and in adult life.

The long-term effect of health education on young people is difficult to assess, though there are indications of progress. For example, recent research suggests that despite public concern about drugs, and their availability, the number of school pupils who have experimented with drugs remains very low. There are indications, however, that other forms of unhealthy behaviour are static or increasing – smoking and drinking alcohol are much more prevalent and a greater cause for concern.

The DES also has responsibility, through the overall funding of the university sector and the payment of grant-in-aid to the independent Medical Research Council, for basic medical education and medical and health-related research. In addition the education service is the major provider of initial training for nurses and staff in the professions supplementary to medicine.

Other health related action includes:

- **The school curriculum:** certain health issues are included within the statutory order for National Curriculum science. In addition, the National Curriculum Council identified health education as one of five cross-curricular themes and issued guidance which identifies nine key components for health education – substance use and misuse; sex education; family life education; safety; health-related exercise; food and nutrition; personal hygiene; environmental factors; and psychological aspects.

- **Health education:** Since 1986, DES has funded local education authority initiatives to counter misuse of drugs and, since 1990 to support general health education.

- **Sport:** sport in schools is the foundation to encouraging greater overall participation in sport. Physical education is therefore a compulsory subject for all pupils between five and 16 in maintained schools. DES and DH are jointly examining what can be done to encourage better co-ordination between locally health based exercise initiatives and efforts by sports clubs and local authorities to promote greater participation in sport.

- **Sports Council:** Sports Council targets for 1988-1993 include:
(a) an increase in the percentage of women and young girls taking part in sport from 38% to 42%

(b) maintenance of the absolute numbers, and therefore an increase in the percentage of young people taking part in sport in the

context of the declining number of 18-25 year olds in the population.

EMPLOYMENT DEPARTMENT GROUP

The Employment Department Group provides help for people with disabilities and long-term health problems who wish to identify appropriate work and prepare for it. The Employment Rehabilitation Service undertakes both these functions, and medical practitioners can make use of its specialist services to seek practical advice for patients. Disablement Resettlement Officers and the Disablement Advisory Service provide help and guidance to individuals and employers about the integration of people with disabilities into the workforce. The Employment Department Group also helps meet the training needs of people with disabilities or long-term health problems, provides help in training and employment through a variety of special schemes such as loaning equipment to individuals or providing grants to employers to alter premises, and enables people with severe disabilities to work in sheltered accommodation.

Health and safety of workpeople and the public affected by work activity is the responsibility of the Health and Safety Commission and Executive. This is carried out through:

- negotiation and definition of standards, which can lead to new legislation;
- issuing guidance on standards and good practice;
- promoting compliance with legislation through inspection, advice and enforcement (170,000 preventive inspection visits were made in 1989-90 with 11,700 improvement and prohibition notices issued and 2,200 successful prosecutions);
- promoting better management of health and safety;
- carrying out research and investigations of accidents and ill-health (in 1989-90, more than 11,000 accidents and incidents were investigated and the Employment Medical Advisory Service made 3000 workplace visits to investigate causes of occupational ill-health).

Cancers and lung disease remain the major apparent causes of work-related deaths, often reflecting exposure levels of many years ago which are now better controlled. Overall, there are possibly 2000 premature work-related deaths; 8000 to which work is a contributory factor; and 80,000 new cases of work-related disease each year. There are gaps in information about work-related ill-health and HSC attach high priority to securing improved information on the scale and pattern of industrial ill-health.

DEPARTMENT OF TRANSPORT

More than 5000 people die on the roads each year, and a further 60,000 are seriously injured and 270,000 slightly injured. The Government has set a target of reducing road casualties by one third by the year 2000 and the Department of Transport is concentrating on three areas to meet the target. First, by raising the level of public awareness so that road safety is seen as an issue

for society. Second, by giving special attention to the most vulnerable road users, including children and the elderly. Third, by concentrating on proven and cost effective casualty reduction measures in vehicle and road engineering. In 1990 the Department of Transport, together with the Department of Education and Science and the Department of Health, launched a major child road safety policy initiative, "Children and Roads: A Safer Way", which provides a focus for action to reduce child road casualties.

MINISTRY OF AGRICULTURE, FISHERIES AND FOOD

A wholesome and safe diet is integral to good health. In ensuring that food is safe for general consumption, MAFF:

- takes action against diseases transmissible from farm animals (successes include the reduction of tuberculosis and brucellosis to very low levels; efforts are now being made to reduce the incidence of salmonella enteritidis in poultry);
- ensures the milk supply reaches the very highest EC standards (the UK is the only country other than Denmark to do so);
- carries out surveillance and research to identify risks to the food supply and ways of managing them.

MAFF is responsible for ensuring that information is available to allow consumers to choose a healthy diet; action is being taken to encourage better food labelling and more consumer education to underpin consumer choice.

DEPARTMENT OF SOCIAL SECURITY

Increased prosperity means that those in all income groups have seen real improvements in their living standards during the 1980s. However, the key role that social security benefits play in maintaining health, particularly amongst the more vulnerable in society, is fully recognised. Through the new structure of income-related benefits introduced in 1988, resources are now directed more effectively to those who need them. Additional resources in real terms have been made available to pensioners, sick and disabled people, families with children and lone parents. The priority accorded to lone parents is also reflected in the new initiative on child support which highlights the parental responsibility for providing proper financial support to their children wherever it can reasonably be expected and will facilitate the payment of maintenance without recourse to the courts.

Recent improvements in disability benefits and the new benefits now being considered by Parliament will add up to a more comprehensive and coherent system of support for disabled people than ever before. The Minister of State for Disabled People, who is a Social Security Minister, is responsible for interdepartmental liaison on all issues affecting disabled people.

The Department of Social Security is working especially closely with the Department of Health to ensure a smooth transition to the new community care arrangements in April 1993. In particular, the social security entitlements of those in residential care and nursing homes will be fully protected.

DEPARTMENT OF TRADE AND INDUSTRY

The Department of Trade and Industry is concerned with the safety of consumer goods and with valid and analytical measurement, upon which the reliable monitoring of many hazards depends. One of its other responsibilities is prevention of accidents in the home. Every year about 5000 people die and around three million need medical attention, making home accidents the biggest single cause of injury. The Consumer Protection Act 1987 provides a strong legal framework to protect consumers from unsafe consumer goods. DTI also mounts safety campaigns aimed at particular hazards or those most at risk. These have contributed to a fall in deaths from more than 7000 in 1966 to 5000 in 1988 (England and Wales).

TAXES, DUTIES AND HEALTH

The Government levies excise duties on products which can be harmful to health – such as tobacco products, alcoholic drink and leaded petrol. Raising these duties can help reduce consumption, or encourage the use of less harmful alternatives:

- The duty on tobacco products was increased in the 1991 Budget by 15%. The Chancellor of the Exchequer said: "There are strong health arguments for a big duty increase on tobacco. In recent years the duty has fallen in real terms and cigarette consumption, having declined in the early 1980s, has begun to turn up again. Raising the duty will help to counter this unwelcome trend." As a result of the Budget the total real terms increase in the specific duty (and VAT) on cigarettes since 1979 is 55%;

- The introduction and widening of the duty differential between leaded and unleaded petrol has encouraged motorists to switch to unleaded and reduced the amount of lead in the atmosphere. Unleaded petrol now accounts for around 39% of the market;

- Since 1988, some low alcohol drinks have been taxed less heavily per unit of alcohol content than higher alcohol drinks in order not to discourage their consumption.

A Health Strategy for England

The way forward – Scope of a strategy – Key areas – Objectives and Targets – Criteria for selection – The discipline of targets – Need for national targets – Identifying major causes of concern – Different conclusions from different vantage points – Public's perception of risks to health – International comparisons – Setting and monitoring targets

An ideal health strategy would be based on complete knowledge of the state of the population's health, a full understanding of the causes of that state of health and the actions needed to improve it, full and absolute power to take the necessary action and an ability to monitor and assess the effectiveness of the actions taken. The world is not ideal; waiting for such a full understanding would mean waiting forever.

5.2 The Government does not propose therefore that this strategy should immediately attempt to address every health and/or health care issue. Little real progress would be likely to result from such an approach. This does not mean the neglect of important areas of health or health care: rather, that knowledge, effort, resources and opportunity need to be specially focused on specific key areas for significant progress to be made. Where knowledge and opportunity are as yet insufficient, the priority must be to improve understanding and ability to respond to the challenges.

5.3 **The Government proposes, on the basis of current knowledge, that:**

- **key areas which are of greatest concern and where there is greatest opportunity for real improvements in health should be identified;**
- **objectives and targets for improvement in health should be set in order to stimulate and direct co-ordinated action;**
- **results should be monitored and assessed;**
- **other key areas should be included over time.**

KEY AREAS

5.4 The strategy will focus on key areas, judged against the following criteria:

First, the area should be a major cause of premature death or avoidable ill health (sickness and/or disability) either in the population as a whole or amongst specific groups of people;

and

Second, the area should be one where effective interventions are possible, offering significant scope for improvement in health;

and

Third, it should be possible to set *objectives* and *targets* in the chosen area and monitor progress towards achievement through indicators.

DISTRIBUTION OF YEARS OF LIFE LOST UP TO AGES 65 YEARS*

BY CAUSE OF DEATH

ENGLAND AND WALES ALL PERSONS 1988

*DEATH UNDER 28 DAYS EXCLUDED

SOURCE: OPCS

figure 19

OBJECTIVES AND TARGETS

5.5 In each key area the first task will be to agree objectives and targets.

- Having clear objectives and targets is an essential discipline. They need to be realistic, but challenging.

- So far as is possible they should be expressed in terms of health improvements or – where appropriate – reductions in risk factors (such as smoking) or precursors of ill-health (such as raised blood pressure) in the population.

- The discipline of targets should be extended to all levels.

- There should be flexibility about the time span for which targets are set. What can be achieved by 2000 in some areas will take longer in others.

- Indicators are essential to target setting. There must be the ability to monitor both the present position and progress.

5.6 Above all, objectives and targets should be agreed by all those who have a part to play in their achievement.

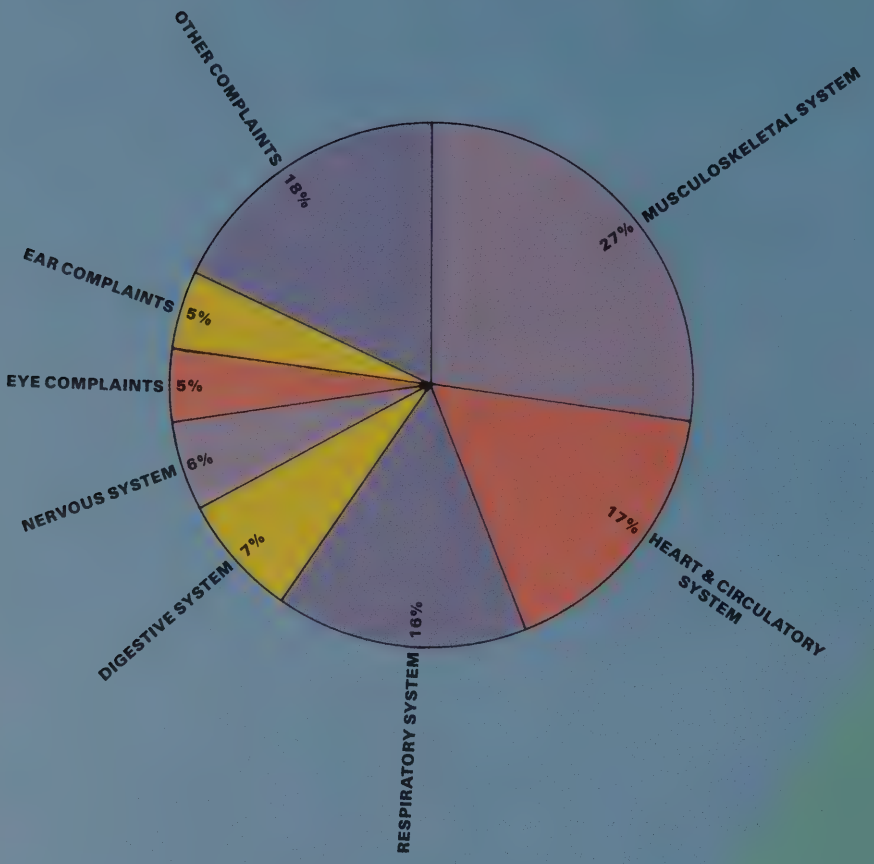
5.7 The remainder of this chapter examines the three criteria to help identify possible key areas. Possible objectives and targets are then discussed in chapter 6.

IDENTIFYING PROBLEMS: "BURDENS OF DISEASE"

The area should be a major cause of premature death or avoidable ill-health

SELF-REPORTED LONG STANDING ILLNESS BY CONDITION*

GREAT BRITAIN ALL PERSONS 1988



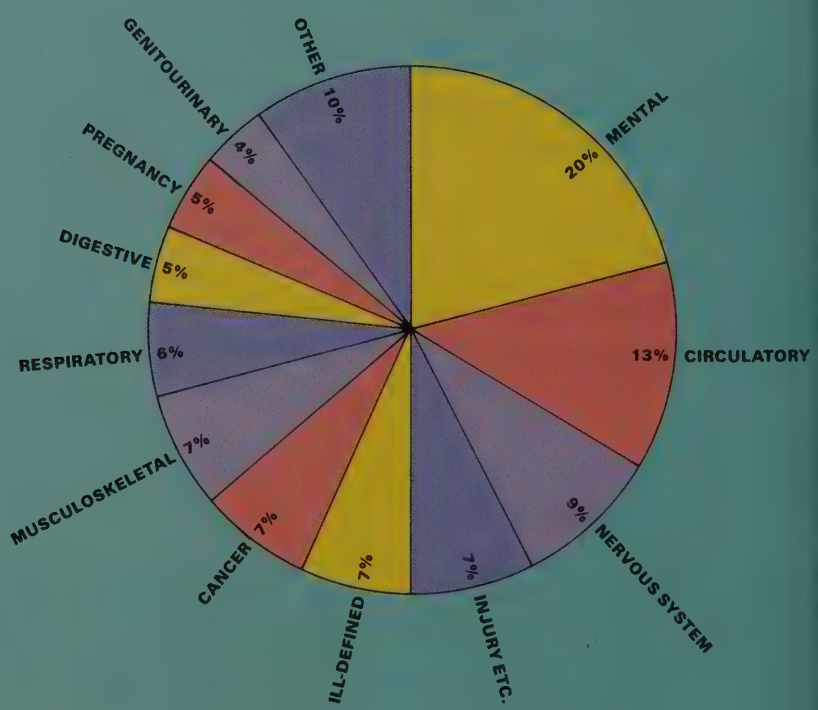
*DATA USED ARE OF SELF-REPORTED ILLNESS
PERCENTAGES MAY NOT ADD UP TO 100 DUE TO ROUNDING

SOURCE: GENERAL HOUSEHOLD SURVEY

figure 20

NHS EXPENDITURE BY DIAGNOSTIC GROUP

ENGLAND AND WALES ALL PERSONS



SOURCE: OPCS (HIPE 1982) ROUTINE NHS COSTING RETURNS 1986/7
NATIONAL MORBIDITY SURVEY 1981/2

figure 21

(sickness and/or disability) either in the population as a whole or amongst specific groups of people

5.8 There are a variety of measures which can be used to identify the most serious problems. One way is to look at three key "burdens of disease": mortality, morbidity and cost.

Death

5.9 The commonest and most comprehensive measure of "health" is that of life and death. National mortality data have been collected systematically since the first half of the 19th century. As well as 'crude' measures of numbers dying, health can be measured in terms of premature mortality, either by numbers of deaths below a certain age (typically 65 or 75), or else in terms of 'life years' lost. Chapter 3 explained the basis of the 'life years lost' approach. *Figure 19* shows the situation for both sexes combined.

Ill-health

5.10 Most ill-health (morbidity) is not fatal. Measuring ill-health is, however, much more difficult than measuring mortality. Whereas one death can be compared with another, morbidity covers a wide spectrum of physical and mental health, and from severe, but short-term pain, to life-long disability.

5.11 Typical measurements of morbidity for which routine data are available include reported time off work through sickness or invalidity, GP consultation rates and use made of other NHS facilities (hospital episode data), levels of long-standing illness as reported in the General Household Survey and registrations of severe visual and hearing impairment. Not all of these are direct measures of health. Measures based on use of services reflect not only morbidity but also the availability of services and individuals' propensity to use them. Absence from work is similarly limited as a measure by the fact that it provides information about the health only of those in the labour market. *Figure 20* shows one measure of morbidity – findings from the General Household Survey.

Cost

5.12 A third measure of the burden of ill-health is cost, mainly cost to the NHS, although attempts are often made to measure wider social and economic costs (eg including lost production, social security etc). *Figure 21* shows NHS expenditure by diagnostic group.

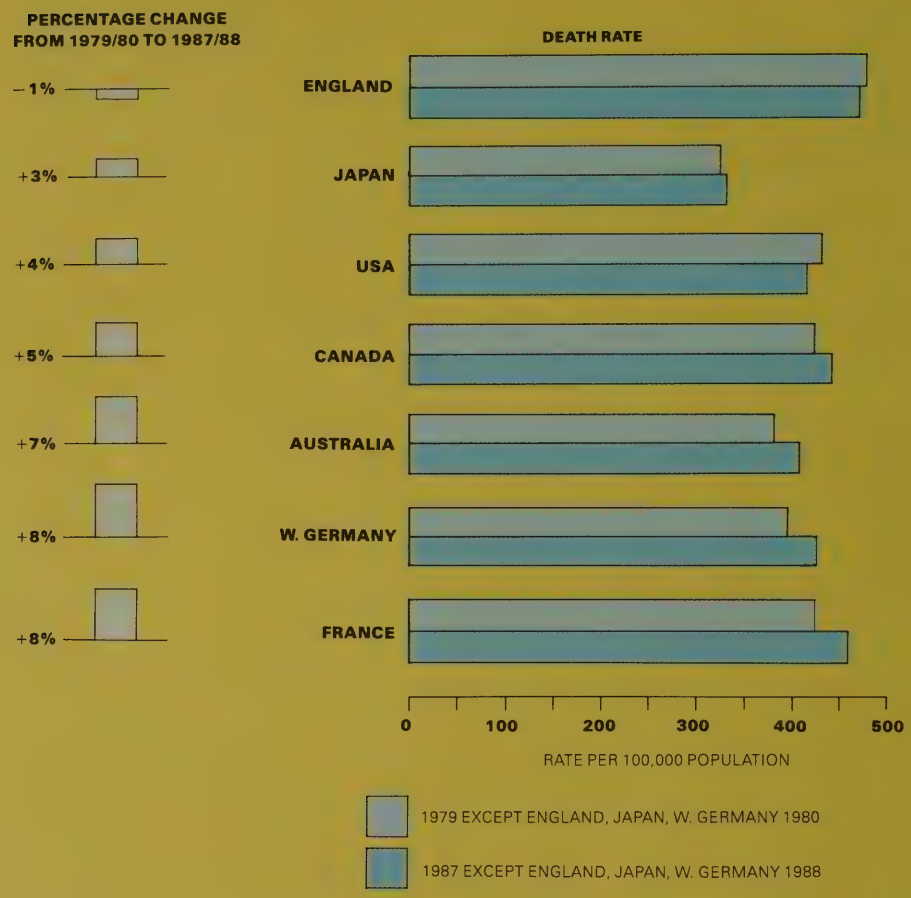
5.13 The striking feature is that the 'problems' each analysis shows differ markedly – with one exception. Circulatory diseases (including coronary heart disease, stroke) are prominent in each case. By contrast, cancers take a heavy toll in terms of premature mortality, but account only for a small proportion of long-standing illnesses. The diseases which cause long-term illness and time off work are not necessarily the main killers, while the pattern of NHS expenditure does not closely follow the pattern of either premature mortality or of self-reported ill-health.

DIFFERENT PERSPECTIVES

5.14 Different perspectives produce different conclusions about priorities. People generally seem more willing to expose themselves to much greater risks than they are prepared to have imposed on them. The chance of an individual

DEATHS FROM ALL MALIGNANT NEOPLASMS

PERSONS AGED 55-64 YEARS

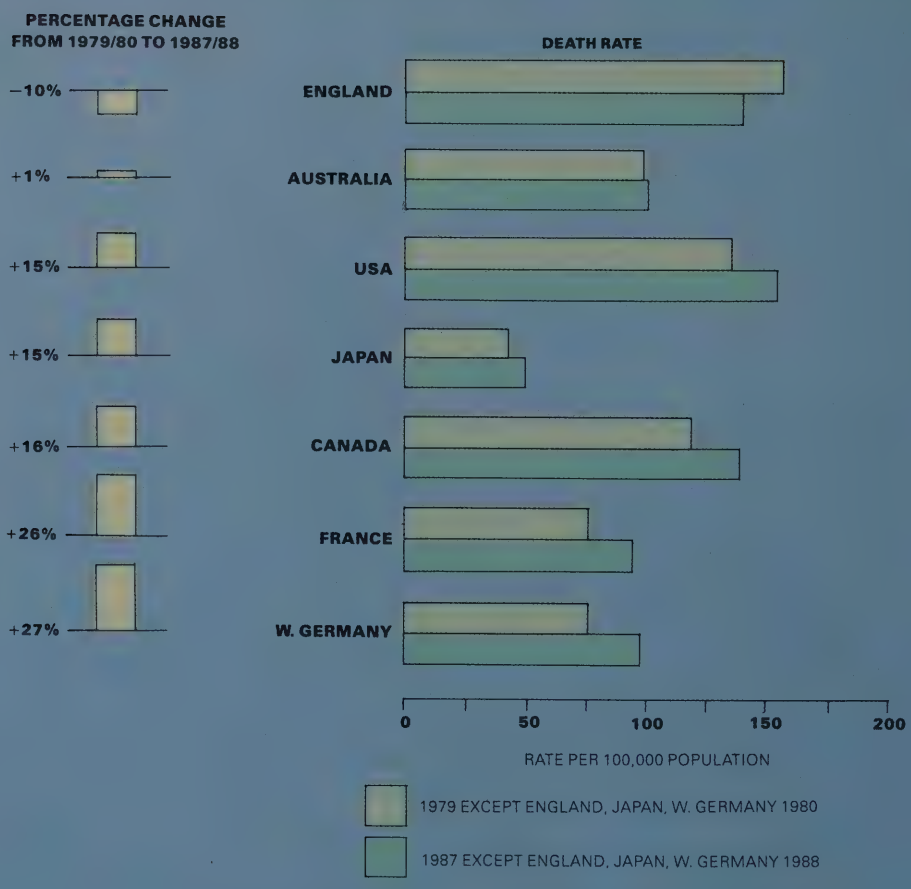


SOURCE: OPCS, WHO ANNUALS (ICD 140 - 208)

figure 22

DEATHS FROM LUNG CANCER

PEOPLE AGED 55-64 YEARS

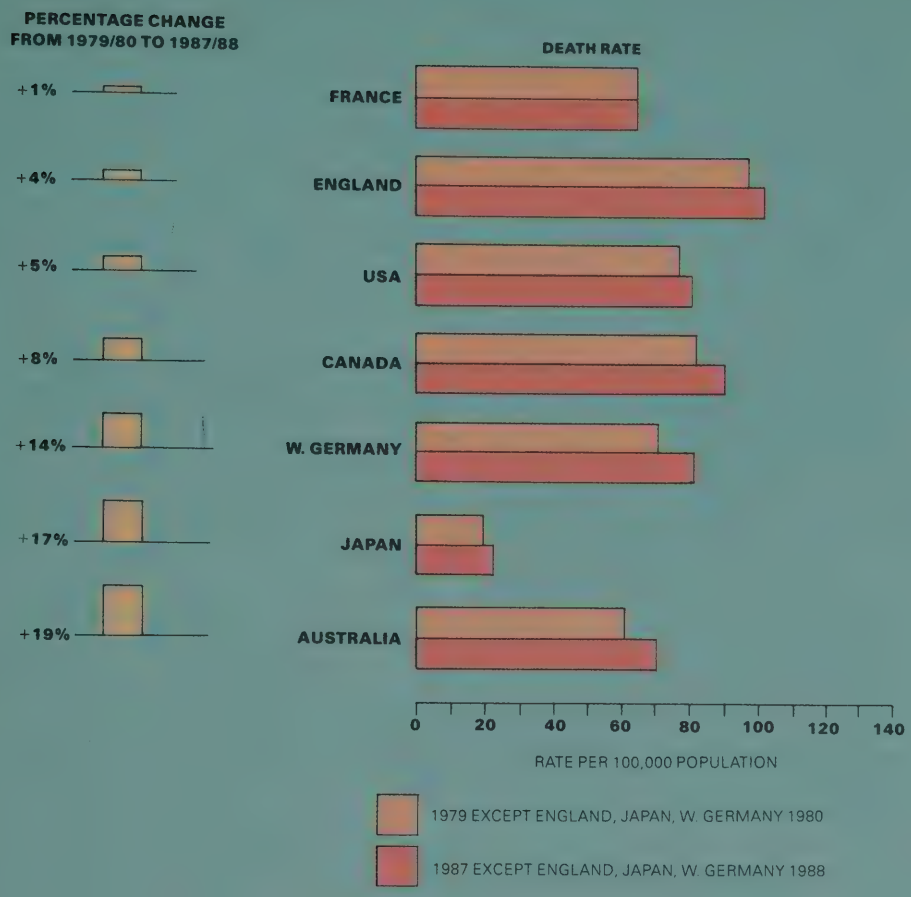


SOURCE: OPCS, WHO ANNUALS (ICD 162)

figure 23

DEATHS FROM CANCER OF THE BREAST

FEMALES AGED 55-64 YEARS

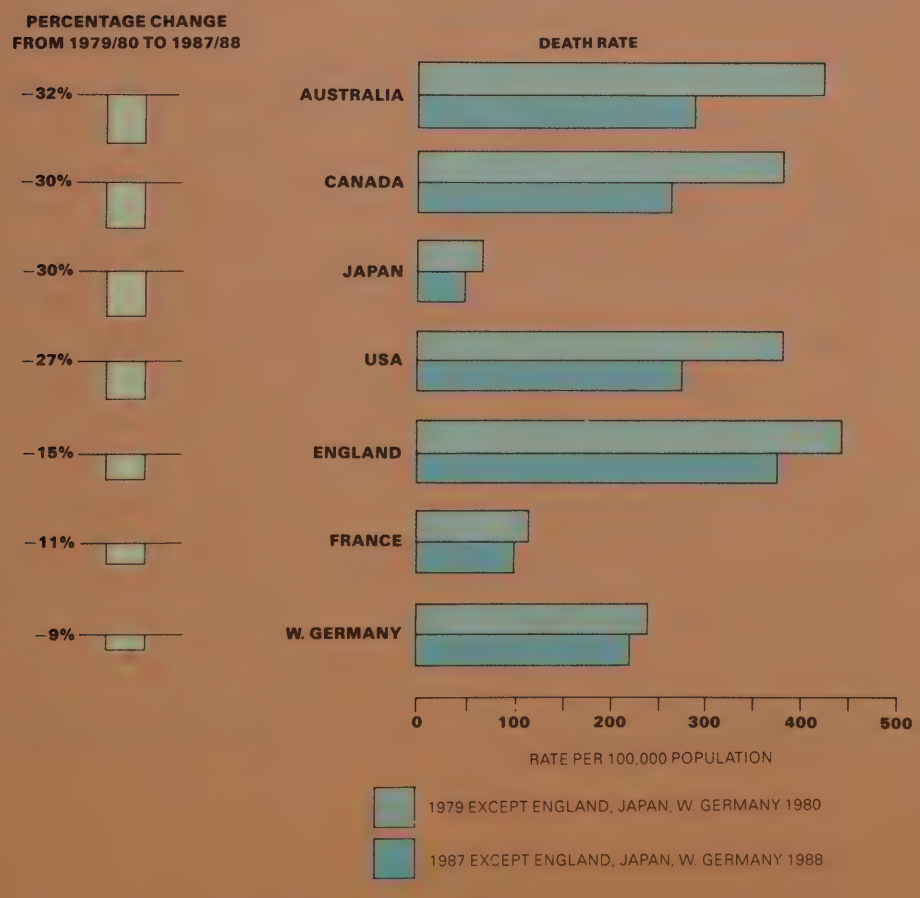


SOURCE: OPCS, WHO ANNUALS (ICD 174)

figure 24

DEATHS FROM CORONARY HEART DISEASE

PEOPLE AGED 55-64 YEARS



SOURCE: OPCS, WHO ANNUALS (ICD 410 - 414)

figure 25

suffering from the effects of chemical pollution are very low compared with the chances of coronary heart disease as a result of smoking, poor diet, and lack of exercise. However, even if the balance of risks is accepted, that is not to say that people would consider the safety of chemicals a low priority. On the contrary, however risky personal health behaviour might be, people are likely to be concerned that safety measures against pollution be taken because the risk, although small, is avoidable although entirely outside their control.

5.15 "Burdens of disease" analysis also fails to highlight the effectiveness of existing action which needs to be sustained. Communicable diseases do not rank high throughout, but their potential for harm remains, if efforts to prevent them were to be relaxed.

SCOPE FOR IMPROVEMENTS IN HEALTH

The area should be one where effective interventions are possible, offering significant scope for improvement in health

5.16 Comparisons of health between different countries, places and groups of people can highlight scope for improvement. The principle is simple. What is achievable in one population should theoretically be achievable in a similar population. In practice, however, the reasons for differences may not be equally amenable to change. Some differences might be due to remediable factors such as poor health service performance, or personal, social or environmental factors such as smoking and eating habits or poor housing. Others may be due to cultural factors, or to geographical or genetic reasons. Most will be a mixture.

INTERNATIONAL COMPARISONS

5.17 In many cases, England's health is very good. Appendix 1 shows England's position on a range of issues against the World Health Organisation's European Region 38 "Health For All by the Year 2000" targets. But as with other countries there certainly remains room for improvement.

5.18 The following charts for persons aged 55-64 compare England's performance – both the rate of improvement and the size of the problem – with six other leading western countries in the important areas of cancer (all malignant neoplasms), lung cancer, breast cancer, coronary heart disease and accidents. In each chart the countries are ranked in order of their percentage change in performance.

Figure 22 shows that England alone has improved, albeit slightly, in reducing death from cancer, whereas each of the other countries has shown increases, in some cases appreciable. Much of this achievement may be attributable to a marked decline in lung cancer mortality amongst men. Nevertheless, England's rate of cancer per head of population remains relatively high.

Figure 23 shows the detail on lung cancer. A 10% decrease in death in England compares well with up to 27% increases elsewhere. But there is considerable scope for more improvement in a disease which is to a large

extent eminently preventable. The aggregate figures mask a further challenge – that for women the death rate has risen, reflecting the fact that the decline in smoking amongst women has occurred only more recently than for men.

Figure 24 shows the comparison for breast cancer in women aged 55-64. England's absolute position is clearly poor, but it has not experienced the significant increases found in some other countries. And it is the size of the problem in England which stimulated the development of the NHS breast cancer screening programme, targeted on this particular age group.

Figure 25 shows that England has made progress in reducing death from coronary heart disease over the past decade, but other countries have done better.

Figure 26 shows that England has achieved a marked reduction in reducing death from accidents and here the country's absolute position is very good.

5.19 Comparisons do not show all the scope for improvement. A 'best' position might be bettered. Moreover, the fact that comparison with performance elsewhere (whether overseas or in different parts of England) shows scope for improvement does not necessarily indicate that it is known how to take advantage of that scope. There must also be knowledge of what is actually effective in making improvements. Nor is it sufficient simply to identify potentially effective interventions; these must also be practical within resource and other constraints, be they fiscal, social or moral. Interventions, though potentially effective, may be impractical by being disproportionate (in cost or scale) to the benefit to be achieved.

SETTING AND MONITORING TARGETS

It should be possible to set objectives and targets in the chosen area, and monitor progress towards achievement through indicators

5.20 The ideal form of targets, at whatever level they are set, is that they should be related to actions known to be effective, be achievable but challenging and be monitorable through indicators.

Related to actions known to be effective

5.21 For targets to be valuable they must be related to what can actually be done. Only where it is known that there is true opportunity for improvement is it worthwhile to set a target.

Achievable, but challenging

5.22 A target which is beyond realistic expectations may perversely be a disincentive to action. At best it will be irrelevant. On the other hand, targets must be challenging. There is similarly little point in aiming low.

Monitorable through indicators

5.23 It must be possible to monitor progress in moving towards targets. Each target must relate to an indicator of the change which is being sought. For example, an indicator for an improvement in coronary heart disease might be a decline in the death rate from that disease. In many cases appropriate indicators of progress are much less obvious – the sort of things which may easily be measured may not be measures of genuine

success. It is also necessary to have the data to quantify the indicator; some exist, some may need to be developed and/or collected.

5.24 The development of indicators and the collection of data are subject to the constraints of resources, practicality and acceptability. Target setting must take these into account. Just as cost-effective interventions are not always available, so too in some cases cost-effective indicators may be lacking. In these cases, too, effort should be directed towards further development of techniques and information policies which will fill gaps.

CONCLUSION

5.25 This chapter has set out a possible framework for a strategy for health and looked in detail at the three criteria to help selection of key areas. Particular constraints such as limitations of current understanding about both levels of ill-health and the scope for improvement, and lack of indicators would mean that strict application of the three criteria would, at the start of development of a strategy, unreasonably limit the scope for what might be included. For this reason, a pragmatic approach is suggested. Whilst striving to develop targets that do go towards the ideal, the Government believes there is a need to set targets in certain key areas knowing that understanding is far from what, ideally, is needed. This will however be on the basis that over time understanding would be improved – with the setting of targets itself acting as a stimulus.

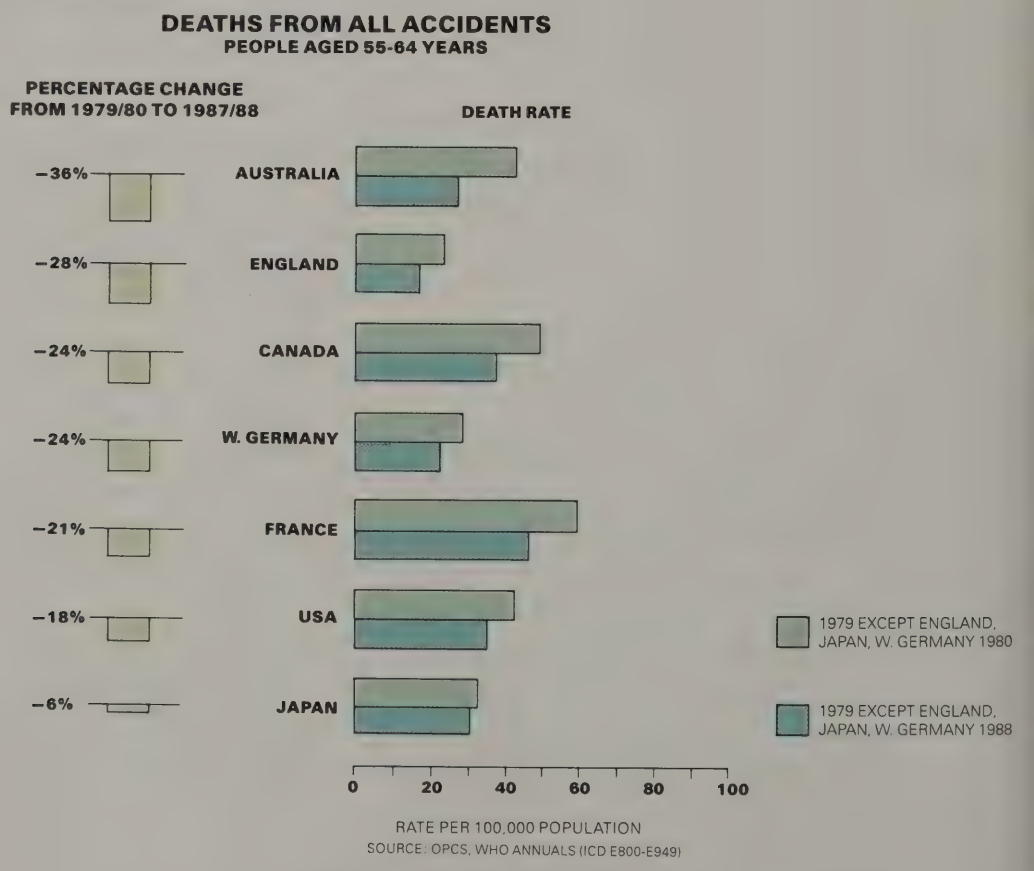


figure 26

THE HEALTH OF THE NATION

CHAPTER 6

Identifying Key Areas: Possible Key Areas, Objectives and Targets

Possible key areas – objectives and targets – selection of initial set of key areas

This chapter suggests possible areas from which an initial selection of key areas might be made. The areas covered reflect the diversity of possible candidates identified by the analysis in the previous chapter.

They include:

causes of substantial mortality

- coronary heart disease
- stroke
- cancers
- accidents

causes of substantial ill-health

- mental health
- diabetes
- asthma

contributing factors to both mortality and morbidity and to healthy living

- smoking
- diet and alcohol
- physical exercise

areas where there is clear scope for improvement

- health of pregnant women, infants and children
- rehabilitation services for people with a physical disability
- environmental quality

areas where there is a great potential for harm

- HIV/AIDS
- other communicable diseases
- food safety.

6.2 This set of possible key areas is by no means exhaustive but the subjects cover those areas which most obviously meet the criteria, together with a range of others which illustrate the types of approaches that could be taken to objective and target setting.

6.3 Annexes A-P discuss each of these areas in detail. *Figure 27* sets out in summary form the conclusions of the discussions. In most cases the areas do meet the criteria but in four instances – for a variety of reasons – they do not appear suitable to be candidates for key areas.

OBJECTIVES AND POSSIBLE TARGETS

6.4 In each of the areas which meet the criteria for selection, both overall objectives and possible targets are suggested. These are summarised at the end of this chapter.

6.5 The targets suggested are of a variety of types. Where possible, targets in a key area are for health

IDENTIFYING KEY AREAS:
POSSIBLE KEY AREAS, OBJECTIVES AND TARGETS
CONTINUED

Area	Criterion 1 Major cause of concern	Criterion 2 Scope for improvement	Criterion 3 Ability to set targets
Coronary Heart Disease	Greatest single cause of premature death	Healthy living Effective treatment	YES
Stroke	12% of all deaths 5% of deaths under 65 years	Healthy living Detection and treatment of raised blood pressure Rehabilitation	YES
Cancers	25% of all deaths	Not for all cancers For some – healthy living Screening for breast and cervical cancers	Not for all cancers Screening targets for breast and cervical cancer + see smoking target
Smoking	Largest single preventable cause of death	Not smoking	YES
Eating and Drinking Habits	Contribution to many aspects of health and ill-health	Healthier eating and drinking habits	YES
Physical Activity	Contribution to many aspects of health and ill-health	More people taking regular physical activity	Not at this stage – further information needed
Prevention of Accidents	Most common cause of death under 30	Improvements in engineering, design, environment etc Education, awareness Legislation and other controls	YES
Health of Pregnant Women, Infants and Children	Key indicator of the nation's health	Wide subject – scope varies for different aspects	YES
Diabetes	4-5% of total health care expenditure on care of people with diabetes	Effective treatment and care	YES
Mental Health	20% of total NHS expenditure	Transition to a district-based service	YES
HIV/AIDS	Greatest new threat to public health this century	Safe sexual and intravenous drug using behaviour	Not at this stage – further information needed
Other Communicable Diseases			
(a) preventable by immunisation	Potential for harm should immunisation rates fall	Immunisation	YES
(b) hospital acquired infection	10% of inpatients have an infection acquired in hospital	Good practice	YES
Food Safety			
(a) foodborne diseases	Cause of considerable degree of ill-health, though not many deaths Underlying rising trend in cases	Improvements in hygiene Increase in awareness Effective surveillance Regulation	Not at this stage – more needs to be known about incidence of food poisoning
(b) chemical safety of food	Undoubted potential for harm to human health in absence of effective measures	Continued research and assessment. Regulation and other controls	Limited ability to set targets in terms of human health
Rehabilitation Services	Wide subject covering a variety of areas of concern	Scope for intervention varies	YES – in specific areas
Asthma	Substantial morbidity – lost schooling and sickness absence	Effective treatment and care	YES
Environmental Quality	Potential for harm to health if standards of protection are inadequate. Unrealised potential for promotion of health and well-being when standards are sufficiently high	Improvement in abatement technologies, stricter standards which are effectively enforced mobilisation of public interest	YES – in most areas

figure 27

outcomes – ie actual improvements in health. Where this is not possible, targets have been suggested which relate to services which are known to be effective in improving or safeguarding health.

6.6 In some cases specific quantified national targets have been suggested. In others no target has been specified. In many cases, it is suggested that opportunities for target setting are greatest and potentially most valuable at local level.

AREAS NOT TO BE INCLUDED

6.7 The four areas which do not appear sufficiently to meet the criteria for selection as key areas are:

- Cancers: although cancers are a very important cause of death and ill-heath, only for some types of cancer are effective interventions available (criterion 2). It would therefore be inappropriate to treat cancers as a single area. The discussion therefore looks separately at breast and cervical cancer for which screening is effective, while the many cancers which are caused mainly or partly by tobacco use are addressed in annex D, on smoking.

- Physical activity: more needs to be known both about current levels of participation in physical activity, exercise and sport, and about current levels of fitness (criterion 3). The current Allied Dunbar National Fitness Survey should help to provide more of this information.

- HIV/AIDS: more needs to be known about the current prevalence of the disease (criterion 3). The current series of anonymised sero-surveys may help to provide further information.

- Food safety: there is currently no sound basis for determining targets for reductions in incidence of foodborne diseases (criterion 3). (Current studies by the Department of Health will provide more information about the actual incidence of food poisoning.) However, the scope for identifying ill-health caused by the chemicals in food using epidemiological data, and consequently the ability to set measurable targets for improvement in human health, is limited (criterion 3).

SELECTION OF INITIAL SET OF KEY AREAS

6.8 It is not proposed that all the possible areas suggested should be included in the final initial national selection of key areas and targets. They are proposed here for consultation. **The Government hopes as a result of consultation to be able to agree a limited definitive initial set of key areas, objectives and targets** including perhaps no more than 5 or 6 areas in the first instance (except that smoking, eating and drinking would naturally accompany coronary heart disease and stroke for which they are risk factors).

6.9 Inevitably this will mean that a number of important areas will not initially be selected as key areas. This is in no way to deny their importance. Indeed, it is at the heart of the approach suggested that the a more comprehensive portfolio should build up over time.

SUMMARY OF POSSIBLE KEY AREAS

Coronary Heart Disease

Objectives

To reduce the occurrence of coronary heart disease and to reduce associated death and ill-health; and to improve the treatment and rehabilitation of those suffering from it.

Possible targets

- 30% reduction nationally in death below age 65 from coronary heart disease between 1988 and 2000;
- Also, perhaps, targets for treatment (eg coronary artery by-pass grafts; 30 minute "door to needle time" for intravenous thrombolytic therapy).

Stroke

Objectives

To reduce the occurrence of stroke and associated death and to ensure the maximum quality of life for survivors.

Possible targets

Options include:

- 30% reduction nationally in death below age 65 between 1988 and 2000;
- 25% reduction nationally in death in the 65-74 year age group between 1988 and 2000;
- Possible targets (national or local) for incidence of stroke, early detection and treatment of raised blood pressure, and rehabilitation of stroke survivors.

Cancers

Objective

To reduce death and ill-health from cancers.

Possible targets

Cancers vary enormously and the scope for change varies from cancer to cancer. Therefore no global target is suggested. Tobacco-related cancers will be reduced by success in meeting targets for smoking. For breast and cervical cancer, targets based on screening programmes already exist:

- to reduce breast cancer deaths in the population invited for screening by 25% nationally by 2000 compared to 1990;
- to ensure that all women in the eligible age group have been invited for cervical cancer screening by the end of 1993.

Smoking

Objective

To reduce death and ill-health caused by smoking, by reducing the numbers of people starting to smoke and increasing the numbers who stop smoking.

Possible targets

- to reduce the proportion nationally of men smoking cigarettes to 22% by 2000 and of women to 21% (reductions of 33% and 30% respectively). The target can further be broken down by sex and age group:

Age in years	**men**		**women**	
	1988 %	2000 %	1988 %	2000 %
16-19	28	20	28	20
20-24	37	25	37	25
25-49	37	25	35	25
50-59	33	20	34	20
60+	26	15	21	15

Eating and Drinking Habits

Objective

To reduce the amount of ill-health and premature death related wholly or partly to eating and drinking habits.

Possible targets

- by 2005 the proportion of the population who derive less than 15% of their food energy from saturated fatty acids should be at least 60%;
- by 2005 the proportion of the population who derive less than 35% of their food energy intake from total fat should be at least 50%;
- by 2005 the proportion of obese adults should be 7% or less;
- by 2005 fewer than 1 in 6 men and 1 in 18 women should be drinking more than the sensible limits of alcohol.

Prevention of Accidents

Objective

To reduce the number and severity of accidental injuries.

Possible targets

Views are invited on the possibility of setting broad national targets for accident prevention. Issues include:

- what indicators (of death and injury) could be used ?
- should targets be for the population generally, for specific population groups, or should both approaches be used ?
- should such targets look only as far as 2000, or beyond that?

Health of Pregnant Women, Infants and Children

Objective

To reduce preventable death and ill-health amongst pregnant women, infants and children.

Possible targets

No single target is possible. Possibilities include:

- all Regional Health Authorities, their District Health Authorities and Family Health Services Authorities to have agreed targets by 1993 for reductions in stillbirths and infant deaths;
- all Regional Health Authorities by 1993 to have reviewed arrangements in consultant maternity units in the light of the recommended level of consultant cover;
- to increase the proportion nationally of infants who are breastfed at birth from 64% in 1985 to 75% or more by 2000;
- to increase the proportion nationally of infants aged six weeks being wholly or partly breastfed from 39% in 1985 to 50% or more by 2000;
- that by 2003, nationally 12-year-olds should have on average no more than 1.5 decayed, missing or filled permanent teeth (with appropriate regional and sub-regional targets).

Diabetes

Objective

To reduce death and ill-health caused by diabetes, principally by ensuring the effective provision of services.

Targets

While it would be possible to set service targets (for example, proportion of GP practices within a

Family Health Services Authority who follow locally agreed protocols for services to people with diabetes) it should in principle soon be possible to set targets using health outcome measures. These would require better access to existing information sources. But the Government would welcome views on the feasibility at this stage of setting targets in areas such as:

- reduction in rates of blindness caused by diabetes;
- reduction in rate of amputations for diabetic gangrene;
- pregnancy outcomes in women with diabetes approximating to those of women without diabetes;
- reduction in number of people with diabetes entering end-stage renal failure:
- reduction in death and ill-health from coronary heart disease among people with diabetes.

Mental Health

Objective

To reduce the level of disability caused by mental illness by improving significantly the treatment and care of mentally disordered people.

Possible targets

In the present state of knowledge it is not currently realistic to set health outcome targets for mental health services. However, it is clear that patients and their carers benefit from the transition from traditional large hospital based care to a district based service. A single measurable target might therefore be:

- to realign the resources currently spent on specialist psychiatric services into district based care, thereby allowing many of the remaining 90 large psychiatric hospitals to be closed before 2000.

Such a target would have to be supported by measures of success in providing appropriate and high quality alternative locally based hospital and community services.

Communicable Diseases

(a) Immunisation-preventable communicable diseases

Objective

To reduce or eliminate these diseases, principally by preventing their spread.

Possible targets

- increase the national target for childhood immunisations from present 90% to 95% coverage by 1995;
- 90% reduction nationally by 1995 on 1989 levels of measles notifications.

(b) Hospital acquired infections

Objective

To reduce as far as possible the incidence of hospital acquired infections.

Possible targets

Targets could be set on the basis of what can be achieved through good practice. These might initially relate to procedures to be adopted. Medical and clinical audit will allow continuing development of target setting and monitoring in individual units.

Rehabilitation Services for People with a Physical Disability

Objective

To enable people with physical disabilities to reach their optimum level of functioning.

Possible targets

Given current developments in the service, and its diverse nature, it is not at present appropriate to set national targets for rehabilitation services. There is however scope for specific targets to be developed to support the widespread and effective delivery of services. Health Authorities could set targets aimed at certain specific disabling conditions, eg incontinence, contractures and pressure sores. In respect of this last an annual reduction of at least 5-10% would be a reasonable target.

Asthma

Objective

To reduce death and ill-health attributable to asthma in the short to medium term by the effective provision of services and in the long term by establishing its aetiology.

Possible targets

It is not appropriate at the moment to set health outcome targets for asthma. It may be better to develop targets for defined populations based on specific aspects of services delivery, such as:

- adherence to published clinical management guidelines;
- the establishment of agreed protocols between GPs and hospital clinicians;
- the development of local strategies;
- take-up of peak flow meters on prescription;
- development of self-management plans agreed between patient and doctor.

Environmental Quality

Objective

To protect and promote the health and well-being of the nation by improving environmental quality and housing conditions.

Possible targets

Health outcome targets are not possible at this stage. Targets for environmental quality already exist in several areas:

- by the end of 1995 the current programme of improvements should be completed thereby remedying most of the breaches in EC Standards for drinking water;
- by 1995 all but a few of identified bathing waters should comply with the EC Bathing Water Directive (the remainder should comply by 1998);
- on a 1980 baseline, reduce emissions of oxides of nitrogen from existing large combustion plants by 30% by 1998;
- on a 1990 baseline, reduce levels of oxides of nitrogen in urban air by at least 50% by 2000;
- by 2000 effective national and supra-national controls should be in place to ensure that air quality meets the WHO Guideline on peak ozone concentration.

Other targets will be developed and **views are invited on the priorities which ought to guide these.** A list of priority areas for action developed by WHO and endorsed by the Government is set out in Annex P. Other information on the Government's strategy and priorities is set out in the environment White Paper "This Common Inheritance", published in 1990.

CHAPTER 7

Monitoring, Effectiveness and Health Outcomes

Action being taken to remedy weaknesses – Directors of Public Health – Central Health Monitoring Unit – New health survey programme – Research and development – Developing health outcomes

Weaknesses in understanding of the effectiveness of interventions, and the ability to monitor progress in a wide number of areas through, amongst other things, health outcome indicators, were highlighted in chapter 5. Department of Health initiatives in this area – vital to the further development of a coherent health strategy – are described in this chapter. They complement other initiatives in the NHS and elsewhere.

DEVELOPING THE ABILITY TO MONITOR THE HEALTH OF THE POPULATION

7.2 Effective monitoring of the health of the population is the starting point for any strategic approach to health. Although in many respects the UK's health data are as good as, if not better than, those collected in other countries, they are still weak in certain areas. Although measuring mortality is routine, there is significantly less information about both ill-health and about the risk factors (such as smoking) from which ill-health arises, and the precursors of ill-health (such as raised blood pressure and raised levels of blood cholesterol).

7.3 The Government is committed to improvement. Four important steps have been taken:

- First, the ability to monitor health has been significantly advanced by the appointment of Directors of Public Health with the function of producing annual reports on the health of their local population.
- Second, the Government has established a Central Health Monitoring Unit within the Department of Health to act as a focus for monitoring and analysing epidemiological information about the health of the population and to improve the epidemiological input into policy making.
- Third, a Public Health Information Strategy is being developed which aims to ensure the Department has the information necessary to support its role on public health issues.
- Fourth, a new national health survey programme is under way, designed to fill gaps in key indicators for monitoring the public health. The new survey programme will begin in autumn 1991. Initially it will consist of two types of survey:
  - an annual *general health and nutrition survey* initially covering adults and concentrating on cardiovascular disease and its associated precursors and risk factors
  - a series of biennial detailed *dietary and nutritional surveys* to be conducted by the Department of Health and Ministry of Agriculture, Fisheries and Food, each covering a specific age group.

BETTER UNDERSTANDING OF EFFECTIVENESS

7.4 The development of better understanding of the effectiveness – and cost effectiveness – of interventions is essential. It is fundamental not only to setting strategic objectives; it is fundamental to all health planning and to each individual decision about how to use resources, from choice of treatment for individual patient to legislation on environmental protection.

7.5 To underpin this, a research and development base for public health and the NHS is necessary. Research and development needs to embrace public health research, clinical research and health service research, and to be closely aware of developments in basic science.

7.6 The new research and development strategy for the Department of Health and the NHS sets out a structure for achieving this by:

- a strategic and managed approach by the NHS to research and development;
- the development within a broad framework of a country-wide research and development programme through Regional Health Authorities – including the setting of national research priorities – complemented by Regional activity;
- a requirement that Regional Health Authorities prepare, publish, resource and implement (and be held to account for) research and development plans;
- collaboration with other research funding bodies in addressing issues of agreed national priority.

7.7 Examples of the contribution research is already making to the assessment of the effectiveness of health care interventions include:

- summaries of current knowledge in particular clinical conditions to assist District Health Authorities in their purchasing role;
- development of outcome measures of primary health care for asthma, diabetes and raised blood pressure;
- development of other health outcome and quality of life indicators;
- skill mix and effectiveness of nursing care;
- cost effectiveness studies of community versus hospital based care for mental illness;
- impact of new technology on investigations in general practice.

DEVELOPING ABILITY TO MEASURE SUCCESS – HEALTH OUTCOMES

7.8 Improving understanding of the ways in which changes in health are measured is central to the development of epidemiologically-based evaluation of health policy at all levels. Outcome measurement – that is measurement of the success of particular actions or sets of actions in improving health – shows not only change, but relates that change to identifiable actions, resources, or events. It enables specification and quantification of objectives increasingly to be not in terms of process, but of improvements to health. It allows the effectiveness of policies to be evaluated. In the long-term it will increasingly be developed as a way of holding the NHS and others to account for the success of their activities.

7.9 Projects under way or about to be launched by the Government include:

(a) **Development of outcome indicators** A working group was set up in 1989 to (i) examine the nature of outcome indicators and how they might be used and linked to health service objectives; (ii) examine the use of routinely available data; and (iii) recommend how work be taken forward. The group has proposed a starter list of outcome indicators which could be produced using data routinely available to the NHS. In addition, essential criteria for valid and reliable indicators have been established. A feasibility study will now assess each proposed indicator against the criteria and make recommendations for the production of indicators. An initial set of indicators recommended by this study will be produced in September 1991.

(b) **National Clearing House** A national clearing house is shortly to be established to collect and collate the most up-to-date information on resource requirements, methodology, data collection systems, analytical and interpretation skills and expert advice on assessment of health service outcomes. It will make these available to the Department of Health, NHS and other statutory and voluntary agencies.

(c) **Outcomes Research** The Department of Health is funding a number of research and development projects on all aspects of outcomes assessment. These include:

— work by epidemiologists and clinicians on the development of indicators of outcome of care, particularly hospital outcomes by specialty and clinical condition; outcome of primary health care for asthma, diabetes, raised blood pressure; and outcome of mental health care.

— follow-up studies on avoidable deaths: £250,000 has been made available for Regional Health Authorities for projects either investigating reasons for high local rates of "avoidable death" or developing "avoidable death" indicators.

— research on better methods for assessing health, ill-health and change in health for use in outcome assessment.

— project linking clinical standards and quality of delivery of care to outcomes.

CHAPTER 8

Making Progress – Achieving Objectives and Targets

From what to how – Shared responsibility – Different approaches in each key area – Common themes – The Government role – English Health Strategy Steering Group

A strategy is valuable only to the extent that it secures progress. The challenge is to ensure the objectives and targets are translated into action.

8.2 In some countries central action stops at the point of setting and agreeing objectives and targets: the **what** has been set, the **how** is left to those concerned to deliver, with central Government monitoring and appraising progress.

8.3 The Government does not believe this is a sufficient response for England. Although the need for delegation and local discretion has been identified as important in an English health strategy, avoidance of central prescription of how action should be taken does not mean the absence of central oversight and responsibility. Furthermore, the existence of the National Health Service, the reforms, and the roles of the Department of Health and other Government Departments provide opportunities for a more concerted approach at national level.

8.4 With some exceptions, the majority of the objectives and targets suggested in this consultation document do not fall within the responsibility of any one agent. Those involved in any area may include:

- individuals
- families
- communities
- health care services
- personal social services
- health professions
- the education service
- voluntary sector
- industry, commerce and trades unions
- the media
- Government, central and local
- international organisations.

8.5 Co-operation is essential: the number and variety of those involved illustrate the difficulty of securing such co-operation. This document has already touched on the core responsibility of the Department of Health within Government to secure concerted action at national level. Concerted action at local level within communities is as – if not more – important.

8.6 There is no single approach to securing progress in the proposed key areas. As each falls to a range of different agencies, so different approaches will be needed to make progress. This is not to say there are no common themes across the different areas: as well as the need for collaboration, themes that recur include the need to

improve capacity to monitor health and appraise the effectiveness of interventions and the need for effective health education.

THE ROLE OF THE CENTRE

8.7 The concerted approach needed to secure improvements in health demands that Government acts in a variety of ways to ensure progress is made. It needs to lead, facilitate and monitor the translation of aspiration into action. Specifically it needs to:

for itself

- adopt appropriate policies and programmes
- ensure that agencies directly accountable to Government play their full part

for the strategy as a whole

- lead and facilitate the translation of aspiration into action
- encourage and where necessary facilitate co-operation between different sectors in the pursuit of the strategic objectives and targets
- monitor and review progress, and review objectives and targets in the light of changing circumstances and advancing knowledge
- develop new key areas.

8.8 Responsibility for this will fall primarily on the Secretary of State for Health. To assist him in this role, the Secretary of State will seek views from a new **English Health Strategy Steering Group.** This group will provide a forum through which the experience and interests of those involved in health can be brought together in support of the strategy for health. Its work will be supported by three expert working groups:

- a group on the **Government's role**, covering the wider public and political dimensions. It will look in particular at health education, the role of industry and the media, and link up with the work of other Government Departments.
- a group on **health priorities** covering the public health issues the strategy needs to address – the epidemiology, the ability to set targets, measure progress and develop scientific interventions. It will oversee the work on specific options for objectives and targets.
- a group on **implementation in the NHS** covering the way in which the NHS should be accountable for and deliver its contribution to the strategy.

8.9 Although the long term purpose of the Steering Group and working groups will be to help take work forward after the Government has responded to the results of consultation on this document, the Government intends to establish them during the consultative period to assist in the scrutiny of responses and preparation of the Government's definitive proposals.

CHAPTER 9

The NHS Role in a Strategy for Health

The NHS role – Translation of targets to local level: key issue for consultation – Regional Health Authorities – District Health Authorities – Family Health Services Authorities – Provider Units – Health Education and Promotion – The Health Education Authority

Although one of the key themes of this document is that responsibilities go beyond the NHS, that does not mean the NHS does not have a major and unique role to play. The NHS reforms have provided the NHS with new opportunities to tackle broader aspects of the country's health, as well as continuing to develop treatment and care services in response to demographic changes and medical advances.

KEY AREAS, TARGETS AND LOCAL ACTION

9.2 Objectives and targets in key areas for health improvements will provide a guide to how the NHS, and others, might respond. But – intentionally – they will not be a blueprint of the action that the NHS and others will need to take at local level. Action at local level must be determined in the light of local circumstances, and other local priorities. The challenge for the strategy and for the NHS will be to make an effective and robust link between national objectives and local action.

9.3 Achievement of targets will require the commitment of everyone in the NHS to the principles and to the specific aims and objectives of the strategy. Without such commitment, no progress will be made. Although targets are likely to be expressed at a global level, they are achieved with individuals through the efforts of each health professional and those who support them. A link must be forged between the target of better health and the actual service which is delivered.

9.4 To harness and direct interest and commitment, the strategy must be built into NHS management systems – contracts, collaborative arrangements, audit, planning, monitoring and review, including the NHS Management Executive's "corporate contracts" with Regional Health Authorities and, in turn, Regions' contracts with Districts and Family Health Services Authorities. Through the Management Executive, the Secretary of State for Health will hold RHAs accountable for seeing that DHAs'/FHSAs' contracts embody action to take forward priorities once they are agreed.

9.5 For the successful adoption and realisation of targets these systems must ensure at all levels:

- the problem to be addressed is understood
- the problem is addressed effectively
- progress is monitored (this will be about the audit of success of individual activities as much as about indicators of change at population level).

9.6 Where national targets are agreed and adopted, the NHS will need to assess:

- ways of deriving targets for the NHS's contribution to the national targets

- ways of agreeing the necessary contribution from each Region
- how far these mechanisms should be extended to DHA and FHSA level.

9.7 These issues will need to be addressed by the NHS, the NHS Management Executive and the NHS Policy Board. The Government intends that discussion of these questions should form a major part of the consultation.

REGIONAL HEALTH AUTHORITIES

9.8 Regional Health Authorities can contribute to the national strategy for health by:

- providing a strategic framework which is agreed and shared by purchasers of health care, which takes account of both national objectives and targets and the particular needs and priorities of each Region
- supporting purchasers in developing and producing local strategies and the production of purchasing plans which translate Regional and local priorities into action
- providing a focus for collaborative working on a Region-wide basis
- agreeing standards for improvements in health jointly with FHSAs, DHAs and GP fund holders against which performance in achieving health objectives can be monitored
- providing an active link between national, Regional and local health programmes and support activities, including those of the Health Education Authority
- encouraging innovation and research.

DISTRICT HEALTH AUTHORITIES

9.9 The DHA's duty to purchase a comprehensive range of high quality health care services to meet the needs of local populations and achieve optimum desirable health outcomes, requires it to plan health promotion and disease prevention services in addition to services for diagnosis, treatment, care and rehabilitation. The continued provision of existing services remains at the heart of their function. Each District Health Authority's responsibilities, to complement those of Family Health Services Authorities, will include:

- collection, analysis and interpretation of routine and ad hoc information about the health of the population, and preparing annual reports which analyse current problems affecting health
- agreeing priority areas for targeting effective service interventions to those populations most at risk and for assessing the impact of services
- working with the local community in promoting and maintaining health locally
- collaborating with others on the development of joint policies and strategies for health promotion and disease prevention, including with FHSAs on primary care, and with local authorities over wider public health issues such as environmental health, outbreaks of food poisoning and accident prevention

- making specific recommendations for achieving health outcome objectives which relate to the purchasing of services by the DHA, as well as pointing out action required by other organisations to help improve the health of the population.

FAMILY HEALTH SERVICES AUTHORITIES

9.10 Family Health Services Authorities have a key part to play within an integrated local health strategy. Like DHAs, FHSAs have responsibility for assessing local needs for family health services, and for planning and developing services to meet those needs. They need to work closely with DHAs, particularly in securing high quality health promotion and disease prevention services and tackling major local health priorities in an integrated way across primary, community and hospital care. In particular, FHSAs need to:

- develop with DHAs joint health profiles of the local population, agree priorities and set targets, and contribute to annual reports by Directors of Public Health on the health of the population
- target cash-limited resources, in conjunction with DHA resources, at areas of greatest need and assess the impact of service developments
- establish consumer groups to feed into the planning process
- establish joint planning arrangements and contribute to joint working with DHAs and Local Authorities, voluntary groups and community groups
- agree joint policies over the service and health programmes shared with DHAs, such as immunisation, child surveillance, cervical and breast cancer screening, health education, and care of elderly people
- encourage and support multi-disciplinary team working and training in primary health care
- fund facilitator services to enable and support organisational change within general practice, including the adoption of minimum standards for screening, audit of records etc
- support family health practitioners in developing high quality, consumer-responsive services which meet local needs.

'PROVIDER' UNITS

9.11 Provider units are those from which DHAs will purchase health care services – in the main, hospitals. Their primary contribution will be the provision of high quality services to patients, as required by DHA and GP Fund Holder contracts. In addition, the hospital sector can:

- ensure that health professionals are able to provide effective patient education and counselling as part of the diagnosis, treatment and care as well as ensuring appropriate ongoing care on discharge from hospital
- maintain an environment which promotes and protects the health of all who come into contact with hospital services
- ensure that all premises are smoke free (purchasers will be able to address this in their negotiations with providers on the quality specifications in their contracts)

- provide more intensive counselling and advice linked with specific health programmes (prevention of childhood accidents, smoking cessation, particularly with advice to general medical and surgical patients) in liaison with the primary care services.

9.12 Family doctors and dentists, community nursing staff, high street pharmacists and opticians have an equally important role to play in the delivery of high quality health care services. For the majority of people they are the most frequent point of contact with the NHS and where they turn to first for treatment and advice. They also have a key role in promoting better health and preventing sickness. Their commitment – and that of their staff – will therefore be central to achieving the aims of the strategy.

9.13 Nurses in the community play a central role both in providing direct nursing care to people in their own homes, in health centres and surgeries and in promoting better health and preventing illness. Together with GPs, they are in the front line of NHS care and have a direct influence over the general health of the population and the demand for acute sector services. They therefore remain a key resource for the NHS of the future; and NHS authorities need to ensure that their skills and talents are deployed to best effect.

HEALTH EDUCATION AND PROMOTION

9.14 A main theme emerging from this consultation document is the importance of health education and promotion in securing good health. The change has already started. Of the recent 25% increase in GP practice staff, many are engaged in additional health promotion activities, with members of the primary health care nursing team. The new contract for GPs is producing benefits – for example, together with the activities of health visitors, it has contributed to the achievement of the national targets for immunisation in only a year.

9.15 District Health Authorities and FHSAs are also involved in more general promotion and education activities in their areas. For instance, most DHAs have a Health Promotion Unit whose role is to co-ordinate and direct the NHS contribution to health promotion and education services within the District, often in conjunction with the Family Health Services Authority.

HEALTH EDUCATION AUTHORITY

9.16 Within the NHS, but with a national role, is the Health Education Authority. The HEA was formed in 1987 by the reconstitution of the then Health Education Council as a Special Health Authority. This helped the HEA develop a closer working partnership with the NHS and begin to influence the latter's strategic planning in the direction of health promotion. Work at local level must reflect, support and in turn be supported by the health education and health promotion activities of the HEA at national level.

9.17 More widely, the HEA provides direct public education, including the UK-wide mass media campaigns on HIV/AIDS. It fosters and supports other activities both nationally and locally. It can provide a framework for co-ordinated action, as with the Look After Your Heart programme. It can fund local activity and research, disseminate new ideas and examples of good practice, and produce resource materials for health and health education professionals, schools, local authorities, community organisations and employers. It is important that the resources it can provide should be used fully by authorities and other bodies in the health education and promotion fields.

Quality of NHS Service

Health and health care: the balance – Clinical care – Quality of Service in NHS – New initiatives – Quality prescribed in contracts – Quality targets required at all levels

The proposals in this document focus primarily on improving health in terms of the incidence, prevalence and effects of disease. The emphasis throughout has been, however, that this necessary refocusing of activity on the prevention of disease and the promotion of good health must **not** be at the expense of NHS treatment and care services. A better balance is needed, not a bias in one or other direction.

10.2 People are concerned that they should receive the best possible standard of care and/or cure as quickly as possible. So far as clinical care is concerned, there have been recent new initiatives in areas including medical audit and education, and examination of care delivery issues, while under their new contracts GPs and family dentists must aim to make services more responsive to consumers and raising standards of care.

10.3 A key part of quality is how care is delivered – such as the provision of information, or the attentiveness or friendliness of staff. The importance of the quality of service in terms of the patient's perception of health care experience should not be underestimated. The quality of service can have a therapeutic value and be of enormous psychological benefit. This is important from first contact with a receptionist, GP or primary health care professional and particularly so for long-stay and terminally ill patients. Good clinical care may not be perceived as such if communications with professionals and the quality of service generally are poor.

NHS – QUALITY OF SERVICE INITIATIVES

10.4 Work is under way in the NHS to achieve improvements to the quality of service. Several health authorities have introduced Total Quality Management programmes. These aim to improve the level of quality at all levels and at all areas of service. Many hospitals have targeted particular areas for improvement, including public waiting areas, individual appointment systems and information for patients. The Department of Health has provided funds for specific projects in these areas. Attention has also been paid to customer-service training for staff, particularly receptionists, clinic and hospital ward staff.

10.5 The NHS Review White Paper "Working for Patients" recognised the very powerful influence which doctors have on the health outcomes of patients using the health services. Participation of all doctors in medical audit and in post-graduate and continuing education is therefore seen as vitally important in order to conduct a systematic critical analysis of the quality of medical care. The influence of other health professions has also been recognised and emphasis placed on the introduction of audit, particularly

in the nursing profession and professions allied to medicine. Work on nursing audit is being taken forward in tandem with other initiatives and a "Framework of Audit for Nursing Services" is to be published. Health care is often delivered by multi-disciplinary teams, and when this is the case joint appraisals of the way they work and the results of that work is ultimately expected to enhance further the quality of patient care.

CONTRACTING FOR QUALITY

10.6 One of the main mechanisms for achieving improved quality of service is the system of contracts for health care, where Health Authorities define the level and quality of service which they require for their patients. The system is in its early stages but it is already clear that in their new purchaser role Health Authorities are giving close attention to quality. Quality standards have been included in District Health Authority contracts and as part of service development plans in the Family Health Service. In addition to clinical measures, these include such important areas as reliable appointments, waiting times for out-patient appointments or maximum waits for patients once they arrive at a hospital for an appointment. They also include other qualitative measures such as improvements in communications both to patients and their GPs and in the physical environment of a hospital or GP practice. As contracting develops, the Government will be looking to both sides of the service – providers and purchasers – to pursue higher quality standards.

10.7 The Government believes quality of service targets are likely to be far more challenging and have the commitment of staff if they are set locally and are part of a general push by management to ensure that the search for improved quality is a high priority and absolutely integral to the delivery of health care. In his letter ((EL(89)/MB/117); 22 June 1989) to health authorities, the Chief Executive of the NHS Management Executive highlighted four areas for improvements in quality of service: out-patient appointments, information to patients, reception arrangements and waiting areas, and customer satisfaction surveys. Regions need to continue to look at these areas to achieve further improvements and also identify other areas for quality improvements where it is possible to set clear quantifiable targets. Out-patient appointment systems is one area which particularly lends itself to the setting of local targets and the **Government will expect local targets to be set**. Continuous improvement to quality must be made by the NHS and in order to do so it is important that other areas for improvement are identified and acceptable standards of service agreed upon. **The Government will therefore be looking to all levels of the service – District Health Authorities, Family Health Services Authorities, providers – to set high quality standards and for Regions to drive this forward**. The NHS Policy Board will, in particular, keep this under review.

10.8 The Government will ensure through the NHS management structure that such targets are both rigorous and met. These proposals will be taken forward by the NHS Management Executive during the consultation period.

Consultation, Next Steps and Summary of Points for Consultation

Consultation – Towards the definitive strategy – Expert working groups – Conferences – Key issues for consultation – Method of consultation – Closing date for comments

The Government intends through this document to start a full and widespread discussion of the proposal for a health strategy for England. It is anxious to receive the views of all those involved to ensure that:

- the aims and objectives of the strategy are shared throughout the country
- the strategy is based on the best available information and expertise.

11.2 The Government intends, in the light of comments received during this consultation, to issue a further document which will define and set in motion a health strategy for England. This will include the first definitive key areas and targets.

11.3 The English Health Strategy Steering Group, together with the three expert working groups (as discussed in chapter 8) will help the Secretary of State for Health in his consideration of the response to consultation and the preparation of the Government's definitive proposals.

POINTS FOR CONSULTATION

11.4 The Government wishes a wide-ranging discussion, while focusing particularly on the specific questions posed in this consultation document. The main points for consultation are:

A The form of the strategy

The proposed strategy aims to concentrate efforts on those areas where there is both the need and the opportunity for improvement. Issues are:

1. Is this cumulative approach based on key areas and targets appropriate?
2. Are the criteria for selecting key areas appropriate?
3. How many key areas should be selected initially?

B Key areas, objectives and targets

In each key area, the first step will be to agree objectives and targets. These must be challenging but achievable.

1. Which should be the first set of key areas?
2. What is the objective in each area?
3. What targets should be set in each area? Who should set these? Which should be national and which local?
4. Where quantified targets have been suggested, are these sufficiently challenging?

C Turning the strategy into action

Objectives and targets are valuable only to the extent that they lead to action and improvements.

1. What must be done to achieve shared commitment to the aims and objectives of the strategy?
2. What are the major obstacles to success? What must be done to resolve these?
3. How should the strategy be reflected in NHS planning systems?

D Future development of the strategy

1. What procedures should be adopted for working up further priority areas into this strategic approach?
2. What further developmental work is needed over and above what is already mentioned in this document to facilitate the further development of this strategic process and the selection of key areas and setting of targets?

METHOD OF CONSULTATION

11.5 Written comments are invited. The Department of Health will also be holding discussions with national and representative organisations. The Government hopes that many organisations will wish to take the opportunity to hold discussions and seminars on this consultation document. The Department of Health will be happy to discuss with those organisations how it could usefully contribute to such activities.

11.6 Written comments and other queries about this document and the issues raised in it should be submitted by **31 October 1991** to:

Health Strategy Unit
Department of Health
Room 06
Wellington House
133-155 Waterloo Road
LONDON SE1 8UG

Possible Key Areas, Objectives and Targets

The following Annexes discuss in detail possible key areas, objectives and targets summarised in chapter 6.

A Coronary heart disease

B Stroke

C Cancers

D Smoking

E Eating and Drinking Habits

F Physical Activity

G Prevention of Accidents

H Health of Pregnant Women, Infants and Children

I Diabetes

J Mental Health

K HIV/AIDS

L Other Communicable Diseases

M Food Safety

N Rehabilitation Services For People with a Physical Disability

O Asthma

P Environment and Health

Coronary Heart Disease

BURDENS

A.1 Coronary heart disease (CHD) encompasses a group of clinical conditions ranging from asymptomatic disease to angina pectoris, acute myocardial infarction (heart attack) and sudden death. It is one of the main causes of death in England (140,509 in 1989 – 26% of all deaths), and is also the main single cause of premature death (to age 65). It is estimated that CHD related illness takes up some 5,000 NHS beds every day; accounts for around 2.5% of total NHS expenditure; and results in about 35 million lost working days.

A.2 The death rate from CHD in England has been declining slowly since the early 1970s although it remains one of the highest in the world – it is about six times as high as in Japan. The rate for men has dropped by around 19% and for women by about 15%. The biggest percentage reductions have taken place in younger age groups, as shown in *figure A1*. The downward trend started earlier and has been more marked in countries such as the United States and Australia. There are considerable variations in the trend between social classes and between different regions of England.

OBJECTIVES

A.3 First, to reduce the occurrence of this disease and to reduce associated death and ill-health. Second, to improve the treatment and rehabilitation of those suffering from it.

SCOPE FOR MEETING THESE OBJECTIVES

(a) Prevention

A.4 CHD is caused by a combination of factors – personal and genetic (such as age and family history of heart disease) – which are unalterable; and factors related to lifestyle, which can be **influenced**. The main risk factors for CHD are now accepted to be cigarette smoking, high blood cholesterol levels, raised blood pressure, overweight and obesity and lack of exercise. All these risk factors are determinants modifiable by changes in lifestyle. When combined they interact and multiply. However, there are also other factors thought to have an effect on CHD, including socioeconomic factors, influences in early life and stress. These are areas where as yet knowledge is limited.

A.5 Because many of the factors which cause it can be influenced, **much heart disease is preventable**. The direct link with lifestyle means that an important way of lessening the risk of heart disease is a change to a healthier way of life. This is clearly recognised by many people, as well as public, private and voluntary sector organisations. Health education is important. England has a national CHD prevention programme, "Look After Your Heart", run by the Department of Health and the Health Education Authority.

A.6 Interest in healthy lifestyles is widespread and increasing. There is, for example, a demand for healthier alternatives to a number of food products and, increasingly, manufacturers are responding – the range of food choices for a healthy diet has never been better. Employers have been quick to see the advantages of maintaining a healthier workforce – nearly 500 in both the public and private sectors are now actively associated with 'Look After Your Heart', covering well over 3 million employees.

A.7 The NHS, too, is playing an increasing part in the prevention of CHD, both through developments in primary health care (eg the new GP contract, the national nurse facilitator scheme) and the development

of the District Health Authority role. Patients at risk from overweight and obesity, smoking, raised blood pressure etc will increasingly be identified in the primary care setting, and appropriate advice, help and treatment given.

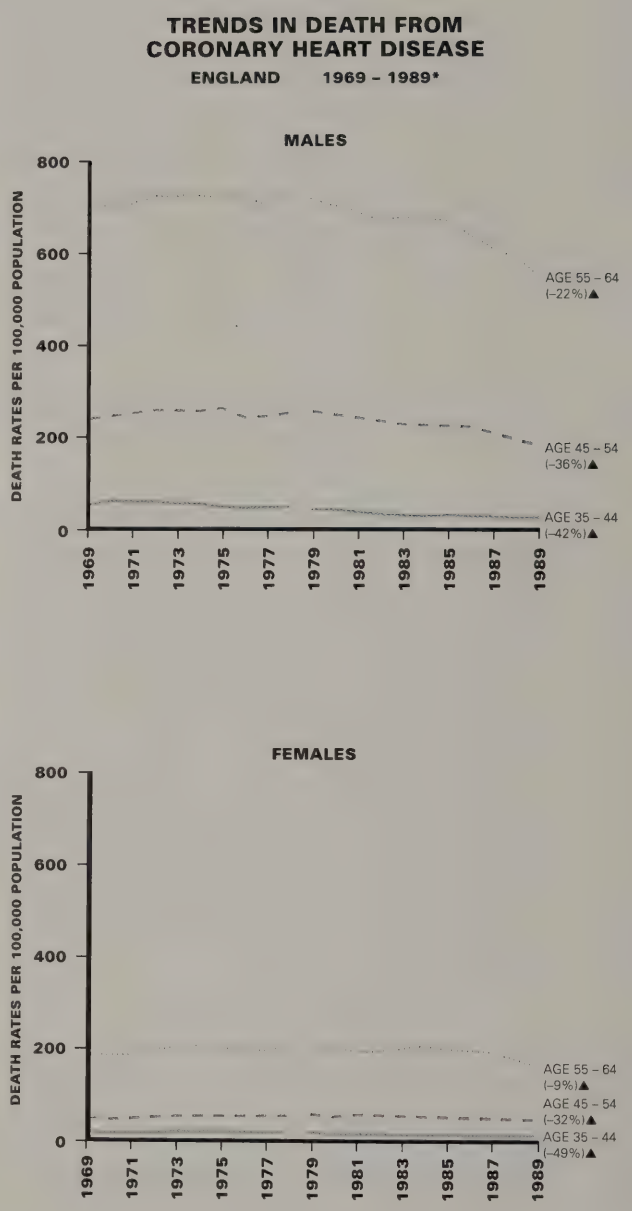
(b) Treatment and rehabilitation

A.8 Though the emphasis of a strategic approach must be principally on prevention, successful treatment has its part to play in reducing premature death and ill-health. The most common way of managing CHD is by drug treatment. In the case of angina possibilities for treatment range from drugs to coronary artery bypass graft (CABG) or angioplasty. For emergency conditions like myocardial infarction, intravenous thrombolytic therapy (ITT) or defibrillation may be called for. Following myocardial infarction, rehabilitation which reduces the debilitating effects associated with unnecessarily prolonged inactivity or restricted activity can benefit patients' self-confidence and physical fitness.

A.9 Since 1984 there has been increasing awareness of the role of ambulance staff in emergency cardiac care. It has recently been announced that all qualified ambulance staff must be trained in defibrillation by the end of 1991. All front line ambulances are now equipped with defibrillators and the Government's objective is that by 1997 every emergency ambulance should have at least one paramedically trained crew member.

POSSIBLE TARGETS

A.10 Though it does not include a specific coronary heart disease target, the WHO European Region 'Health For All by the Year 2000' strategy does have a target for all circulatory diseases, namely to reduce mortality in the Region from these diseases in people under 65 by at least 15% from 1980 to 2000. Circulatory



*DISCONTINUITY BETWEEN YEARS 1978 AND 1979 DUE TO CHANGE IN CODING
▲PERCENTAGE CHANGE FROM 1969 TO 1989

SOURCE: OPCS (ICD 410:414)

figure A1

disease includes not only coronary heart disease but also stroke and other conditions. Between 1980 and 1989 the death rate in England from diseases of the circulatory system in the population of England aged under 65 fell by 29%, thus considerably exceeding the WHO target.

A.11 Although there is no current national target for reduction of heart disease in England, the 'Look After Your Heart' programme aims to contribute to a decrease of 25% in premature deaths from coronary heart disease by the year 2000. However, given the scope for further action **a target of 30% reduction nationally in death under 65 years from coronary heart disease between 1988 and 2000 would appear to be achievable**.

A.12 Prediction of future trends is subject to wide errors because of the multiplicity of factors that need to be estimated, including the likely impact of preventive and medical interventions, trends in risk factors, and the effect of birth cohorts each with different risks of disease. On some extrapolations of recent trends, a target reduction of 30% might be thought to be little more than a continuation of current trends. However, after an initial review of trends in England and other countries, the Government's assessment is that, in the light of all the factors, the suggested target is both challenging, yet achievable.

A.13 The main risk factors for coronary heart disease which can be influenced – smoking, diet (including blood cholesterol), and physical fitness – are discussed in Annexes D, E and F. Raised blood pressure is discussed more fully in Annex B (on Stroke).

A.14 It is also possible that specific targets could be set for treatment:

- the effectiveness of ITT decreases with time from the onset of myocardial infarction. A possible target of "door to needle" time following arrival at hospital of 30 minutes might be appropriate

- there currently exists a target for numbers of coronary artery bypass grafts (CABGs). In 1986, a target of 300 CABGs per million population (pmp) was set. Between 1978 and 1985 numbers of operations rose from 57 pmp to 210 pmp. This rise however slowed down and on latest (1987) figures the rate for the UK as a whole was 225 pmp (some 12,820 procedures). The present target of 300 per million population is significantly below most targets adopted by other countries. Strenuous efforts are required to reach the present target (which should have been attained by the end of 1990).

A.15 The Government would welcome views on target setting for the whole range of treatments of CHD. These might include percutaneous transluminal coronary angioplasty as well as CABGs.

STROKE

BURDENS

B.1 The term "stroke" encompasses pathological conditions such as cerebral infarction, intracerebral haemorrhage and subarachnoid haemorrhage. It is one of the commonest causes of death in adults. In 1989 there were 63,407 stroke deaths in England, approximately 12% of all deaths. Of these 5,067 were under 65 years, and 11,384 in the 65-75 age group (approximately 5% and 9% of all deaths in these age groups respectively).

B.2 Strokes are a major cause of disability and institutionalisation among elderly people. It is estimated that stroke related illness takes up just under 16,000 NHS beds every day and accounts for about 7.7 million lost working days each year.

B.3 In England, as in other western countries, the incidence of stroke and resulting mortality have both been falling for several decades. As shown in *figure B.1*, between 1969 and 1989 in people under 65 stroke mortality in England dropped by about 50%. As for coronary heart disease, the biggest percentage reductions have been in younger age groups – 49% in men and 58% in women aged 40-49.

OBJECTIVES

B.4 To reduce the occurrence of stroke and associated death and disability and to ensure the maximum quality of life for survivors.

SCOPE FOR MEETING THESE OBJECTIVES

(a) Prevention of stroke

B.5 Like coronary heart disease, stroke is caused by a combination of factors, some unalterable, such as family history and age, but others **which can be influenced**. The main risk factor for stroke which is amenable to intervention is raised blood pressure. Stroke is uncommon in people whose blood pressure is below normal levels; the risk of stroke rises with increasing blood pressure, particularly at higher levels. Raised blood pressure alone may account for up to 60% of all strokes.

B.6 Blood pressure can be reduced:

- by changes of lifestyle. Of the major contributors to raised blood pressure, obesity, excessive alcohol and salt intake are amenable to change. The very considerable opportunities for individuals, employers, the NHS, public, private and voluntary bodies are generally similar to those for coronary heart disease

- by early detection and treatment, usually in the primary care setting.

B.7 Smoking too has an effect on stroke. Recent studies comparing the incidence between smokers and non-smokers have highlighted the increased risk of stroke that results from the combination of smoking and raised blood pressure.

(b) Rehabilitation after stroke

B.8 There is some evidence that effective rehabilitation after stroke can improve outcomes and reduce morbidity. It is particularly likely to be effective as part of a well defined rehabilitation service. Effective rehabilitation should encompass the physical, psychological and social management of the disabilities which result from stroke. If they are to be able to regain the maximum independence of life those recovering from stroke should have access to appropriate services, including physiotherapy, nursing, occupational therapy and speech therapy, as well as suitable equipment, housing and transport.

POSSIBLE TARGETS

(a) Reduction in Premature Death

B.9 The current trend of mortality from stroke remains downward. The reduction in mortality in under 65 year olds was 32% between 1980 and 1989. Between 1987-89 in the same age group, the fall was 12%. In the USA a similar downward trend in stroke mortality occurred, but there is now a marked reduction in the rate of decline amongst under 65s which has been evident since the early/mid 1980s. Given the multifactorial nature of stroke, such a reduction in the rate of decline of mortality could also occur in this country, especially since the rapid reduction in mortality rate experienced to date is partially unexplained. Equally, with the widespread adoption of a healthier lifestyle and further progress in detection and treatment of raised blood pressure, the trend could become steeper.

B.10 Options for a target for reduced mortality might include:

- a reduction in rate of death below age 65 from stroke between 1988 and 2000. A target of perhaps 30% nationally would appear to be achievable.

- a reduction in rate of death in the 65-74 year age group over the same period. An achievable figure for this might be 25% nationally.

(b) Others

B.11 The Government would welcome views on other targets that might be developed. Possibilities would include:

i. Reduced incidence of stroke: the Government would welcome views on the feasibility of targets for incidence (either national or local) and of collecting the data necessary for setting and monitoring such targets.

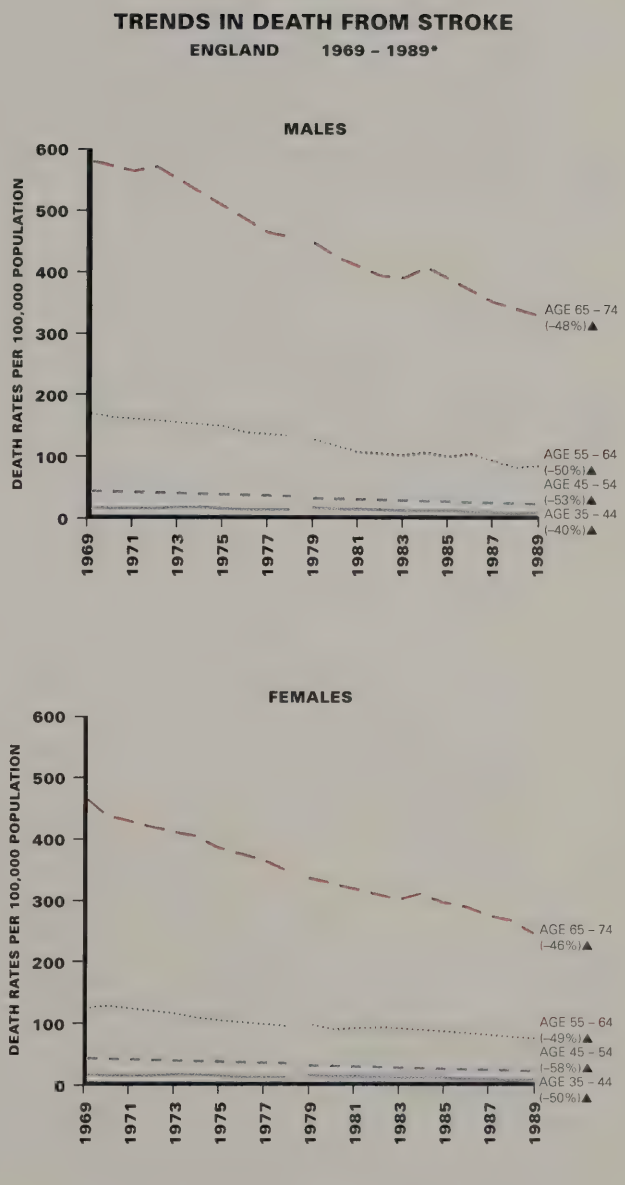


figure B1

ii. Early detection and treatment of raised blood pressure: targets might be developed either nationally or, perhaps more profitably, locally for screening and treatment of raised blood pressure. Views are welcome on the value of such an approach, on the population groups for whom it would be appropriate, and on the ways in which such targets might be monitored.

iii. Rehabilitation: views are invited on the feasibility and value of setting targets in relation to rehabilitation. Options would include targets for the proportion of stroke survivors who are able to live outside institutional care after a given period.

CANCERS

BURDENS

C.1 After coronary heart disease, cancers are the most common cause of mortality. In 1989 cancers accounted for 25% of all deaths and 26% of the total life years lost under age 65. Around 7% of NHS expenditure goes on cancer treatment and prevention.

C.2 Cancers include a large number of very different conditions. In men, the most common are lung cancer (25% of total registrations in 1985), followed by skin cancer [other than melanoma] (13%) and cancer of the large intestine and rectum (11%). In women, breast cancer accounts for 22% of registrations, cancer of the large intestine and rectum 12%, skin cancer (other than melanoma) 11%, and lung cancer 10%. In terms of deaths under age 65, the most frequent causes are lung cancer in men and breast and lung cancers in women.

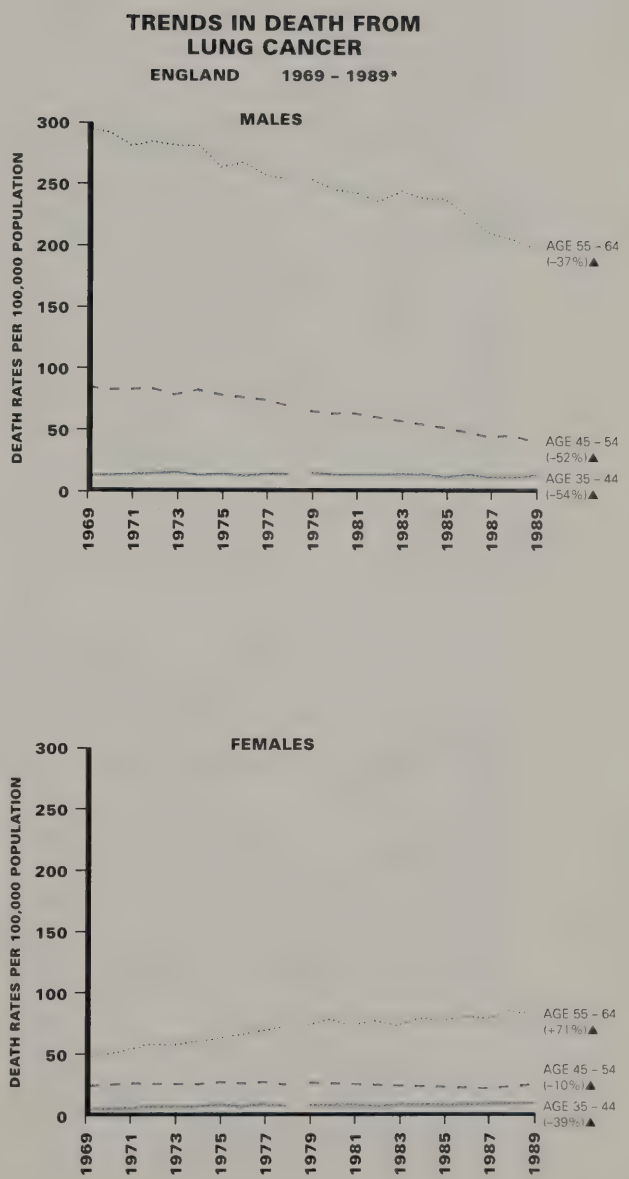
C.3 Overall rates of cancer incidence and mortality have changed little since the mid-1970s, although death rates under age 65 have declined, particularly amongst males. There have also been changes in the balance between different cancers. Skin cancers for example have increased, while stomach cancers have decreased. *Figures C1 and C2* show trends in three cancers – lung, cervical and breast.

OBJECTIVE

C.4 To reduce death and ill-health from cancers.

SCOPE FOR MEETING THIS OBJECTIVE

C.5 Cancers vary enormously and the scope for reducing the ill-health and death they cause varies commensurately. Some can be prevented, some cannot.



*DISCONTINUITY BETWEEN YEARS 1978 AND 1979 DUE TO CHANGE IN CODING
▲PERCENTAGE CHANGE FROM 1969 TO 1989
SOURCE: OPCS (ICD 162)

figure C1

Early detection is valuable in some cases, but not in others. Some cancers can be treated, some as yet cannot.

(a) Prevention

C.6 The causes of cancer are not fully understood. It is estimated that up to 85% of mortality is potentially avoidable. The most significant factor is undoubtedly tobacco. Tobacco use accounts for around 30% of all cancer deaths, including about 90% of the 32,500 deaths in England from lung cancer each year. Diet may contribute to a variety of cancers, being responsible for at least 10% of the total. Current evidence suggests that less than 2% of cancer deaths are caused by environmental factors, such as air pollution and ionising radiation, which cause so much public concern.

(b) Screening and early detection

C.7 There has been considerable effort in recent years to develop effective and cost-effective methods of detecting cancers when they are curable. These include the introduction of screening programmes for cancer of the breast and cervix.

(c) Treatment

C.8 The standard methods of cancer treatment are surgery, radiotherapy and chemotherapy, singly or in combination. The effects have been estimated as:

cured by surgery alone 22%

cured by radiotherapy alone 12%

cured by a combination of surgery and radiotherapy 6%

cured by chemotherapy alone 1.6%

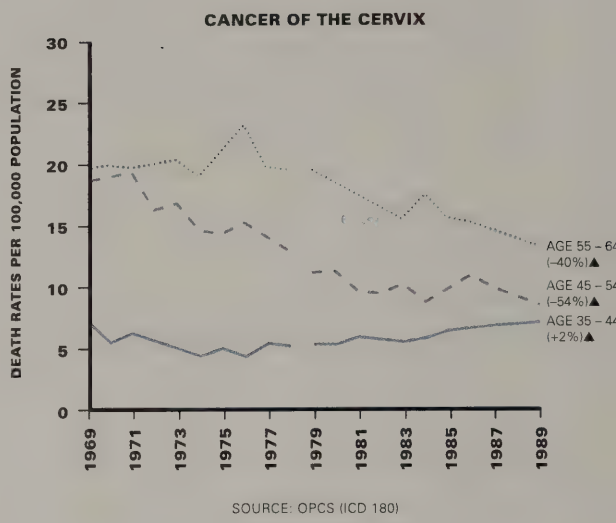
cured by chemotherapy combined with other methods 2.5%

Hormone therapy is also increasingly used.

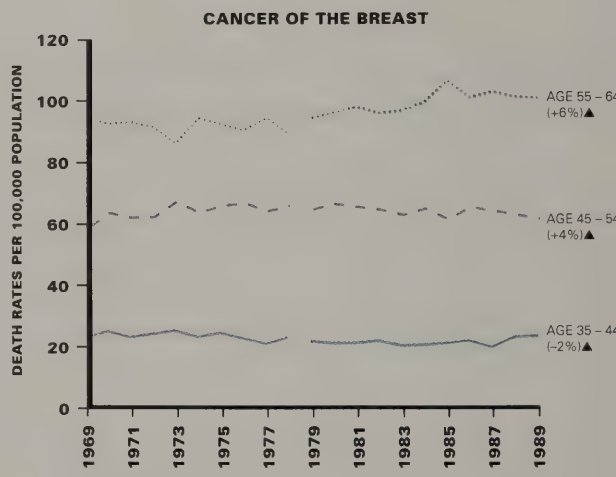
POSSIBLE TARGETS

C.9 Cancers are a heterogenous group, and must be tackled as such. The scope for change varies from

TRENDS IN DEATH FROM CANCER
ENGLAND FEMALES 1969 - 1989*



SOURCE: OPCS (ICD 180)



*DISCONTINUITY BETWEEN YEARS 1978 AND 1979 DUE TO CHANGE IN CODING
▲PERCENTAGE CHANGE FROM 1969 TO 1989

SOURCE: OPCS (ICD 174)

figure C2

cancer to cancer, and it would be wrong to treat them as a single subject. This document therefore concentrates on two types: first, those cancers where tobacco is the major cause are dealt with by Annex D on smoking; second, the two cancers, breast and cervix, where cost-effective screening is possible and has been implemented.

C.10 The current position on these latter is:

Breast cancer

The causes of breast cancer are not fully understood, though reproductive history and obesity are thought to play a part. International comparisons suggest that difference may be due, amongst other things, to social and environmental factors. England has one of the highest rates in the world of breast cancer mortality. About 13,000 women die of breast cancer each year. To combat the problem, the NHS Breast Screening Programme was introduced in 1987, one of the first national programmes of its kind in the world. Women aged 50-64 are being invited for mammographic screening at three-yearly intervals. Successful screening detects the disease at a stage when there is scope for effective treatment. **The aim of the programme is to reduce breast cancer deaths in the population invited for screening by 25% by 2000 compared to 1990.** To achieve this target the programme aims to ensure that all women in the eligible group have been offered and encouraged to accept screening during this period.

Cervical cancer

About 1700 women die each year from cervical cancer. Early detection through screening of changes in cells of the cervix which *may* progress to cancer can significantly reduce mortality. The majority of women who die from cervical cancer have never been screened. The UK is now the first country in the European Community to have a comprehensive cervical screening service based on computerised call and recall. All District Health Authorities and Family Health Services Authorities in England have now implemented these systems and the intention is that screening should be available to all women between the ages of 20 and 64 at least every five years. The current target is that **all women in the eligible age group will have been invited for screening by the end of 1993**. In addition, target payments have been introduced for GPs who achieve coverage of 50% or 80% of the women registered with them.

SMOKING

BURDENS

D.1 Smoking is the largest single preventable cause of mortality. It accounts for a third of all deaths in middle age (40-64 years).

- In addition to cancer of the lung (90% of which is smoking related) smoking also contributes to cancer of the mouth, larynx, pharynx, oesophagus, pancreas, bladder and other organs.
- It is a cause of about 20% of all coronary heart disease deaths and an important risk factor for stroke, particularly when it occurs in association with other risk factors such as raised blood pressure.
- Cigarette smoking is one of the main causes of chronic obstructive airways disease.
- There is some evidence that most cases of aortic aneurysm and intermittent claudication (pain in the leg when walking) due to peripheral vascular disease are associated with smoking.
- Smoking in pregnancy is associated with low birthweight.
- The inhalation of environmental tobacco smoke (passive smoking) carries a small, but not insignificant, risk of lung cancer in adults and respiratory disease in infants and children.

D.2 Currently, 32% of the population smoke cigarettes – 33% of men and 30% of women. This has fallen from 45% in 1974.

OBJECTIVE

D.3 To reduce death and ill-health caused by smoking, by reducing the numbers of people starting to smoke and increasing the numbers who stop smoking.

SCOPE FOR MEETING THIS OBJECTIVE

D.4 Reduction in smoking prevalence depends fundamentally on the choices made by individuals. However, experience has demonstrated that there is much that can be done to support individuals by giving them information, advice and practical help. There are roles for Government, the NHS, health educators, voluntary and community groups and employers, including:

- health education, particularly that aimed at discouraging the young from taking up the habit in the first place (for example the Department of Health and Health Education Authority's "Teenage Smoking Programme")
- health promotion advice from primary health care staff and others on the risks of smoking, and techniques of quitting
- workplace (and other public area) smoking policies – in NHS hospitals for example
- continued recognition of the importance of controls on advertising of tobacco and of the health consequences of changes to tobacco duty levels and therefore price.

POSSIBLE TARGETS

D.5 Currently, some 33% of men and 30% of women smoke cigarettes. Predictions of future trends are hard to make and are subject to wide error. However, if activity on smoking is maintained at least at present levels, on current trends it could be expected that by 2000 this might drop to something like 24% for both sexes. This would represent a reduction of about 27% in men and 20% in women.

D.6 However, the Government suggests that efforts be made to reach a target somewhat in excess of current trends. **Bearing in mind current age and sex distribution of smoking and current trends, a suitable target for 2000 might therefore be to reduce the prevalence of cigarette smoking to 22% in men and 21% in women (reductions of 33% and 30% respectively).**

D.7 The slightly lower percentage reduction for women does not represent a difference of ambition – on the contrary, it would actually represent a greater percentage improvement on current trends than for men. Similarly, the higher intended prevalence figure for men in 2000 is principally a product of demography – women tend to live longer, and elderly people tend to have the lowest smoking prevalence. Hence, the women's total is more heavily weighted by the elderly women non-smokers.

D.8 It would be sensible to set age and sex specific targets, to provide a more detailed set of goals at which to aim. The information with which to monitor progress is available every two years from the General Household Survey. Such targets might be as follows:

Age in years	men		women	
	1988	2000	1988	2000
	%	%	%	%
16-19	**28**	**20**	**28**	**20**
20-24	**37**	**25**	**37**	**25**
25-49	**37**	**25**	**35**	**25**
50-59	**33**	**20**	**34**	**20**
60+	**26**	**15**	**21**	**15**

REDUCING NUMBERS STARTING TO SMOKE

D.9 The overall target for reduction in smoking will be achieved in part by existing smokers quitting, and in part by other people choosing not to take up the habit. In older age groups reductions will principally come through quitting, since it is uncommon for older people to take up smoking. Reductions in the younger age groups, particularly teenagers, will on the other hand largely reflect success in lowering the numbers of young people who start to smoke. In the long-term it is clearly this latter approach which offers the greatest scope for reducing overall levels of smoking in the population.

D.10 The current prevalence of smoking amongst children aged 11-15 in England is 8%. The Health Education Authority's Teenage Smoking programme aims to reduce this by one third by 1994. Longer term targets will need to be considered at the end of the programme.

SMOKING IN PREGNANCY

D.11 It is important for the health of both mother and child that women do not smoke during pregnancy. Smoking during pregnancy is associated with low birthweight and also with a 28% increase in perinatal mortality in babies.

D.12 In recognition of the need for further action, the Government recently announced funding of £1m over two years for the Health Education Authority to carry out a project in this area, and to be launched later in 1991. The project will aim to provide information and support to women to enable them to stop smoking during pregnancy. It may also help to provide more data on smoking prevalence during pregnancy, and it may be possible using this and other material to consider whether useful targets could be set.

Eating and Drinking Habits

INTRODUCTION

E.1 Food ought to be enjoyable as well as providing the energy essential to life. Eating a variety of foods which give a good balance of nutrients is vital for the proper working of every part of the body. The main nutrient groups needed for healthy growth and development and for the continuing repair and renewal of the body throughout life are protein, carbohydrates, fats, vitamins and minerals.

E.2 Nutritional deficiencies no longer present a major public health problem in England, and an improved diet has contributed to a longer lifespan. Nevertheless many people still eat and drink in ways which, over time, can contribute to the risk of developing serious ill-health and of premature death. As Annexes A, B and C make clear, people's eating and drinking habits may play a significant (though by no means the only) part in the development of coronary heart disease, stroke and probably some cancers. Current studies estimate that dietary factors and smoking together account for at least half of all coronary heart disease (some 70,000 deaths) in the country. Obesity is a diet-related condition whose complications include diabetes and gallstones.

E.3 Many people enjoy moderate drinking. However if consumed to excess or at the wrong time, alcohol can cause significant physical, psychological and social harm. The medical Royal Colleges have recommended 21 units of alcohol a week as a sensible limit for men, and 14 units per week as a sensible limit for women. A unit is the equivalent of 8 grammes of alcohol, approximately half a pint of beer, a glass of wine, or a pub measure of spirits.

E.4 Alcohol misuse can be associated with obesity (particularly in the early stages of heavy drinking) and it is possible that alcohol accounts for raised blood pressure in 10-15% of patients with the condition. In 1989 deaths from cancer of the mouth, pharynx, larynx, oesophagus and liver totalled 8,963 (England and Wales), in which excessive alcohol consumption (particularly in combination with tobacco), is an important risk factor. In the same year deaths from chronic liver disease and cirrhosis, which are strongly associated with alcohol misuse, totalled 3,023 (England and Wales).

OBJECTIVE

E.5 To reduce the amount of premature death and ill-health related wholly or in part to eating and drinking habits.

SCOPE FOR MEETING THIS OBJECTIVE

E.6 The scope for improvement in the national diet can be measured by comparing information on what people are eating with the model of a healthy diet derived from the expert advice of the Committee on the Medical Aspects of Food Policy (COMA).

E.7 COMA's current advice on the broad changes which people should make in their eating habits is as follows:

- to reduce the amount of energy from saturated fatty acids to 15% or less of their food energy intake;
- to reduce the amount of energy from total fats to 35% or less of their food energy intake;
- to eat less non-milk extrinsic sugars and to eat sugary foods less often;
- to seek ways of eating less salt;

- to replace fatty and sugary foods by cereal and starchy foods;

- to avoid an excessive intake of alcohol.

E.8 Information on people's purchasing and eating and drinking habits is derived from surveillance – mainly data from the National Food Survey (collected and published quarterly by the Ministry of Agriculture, Fisheries and Food), from the Dietary and Nutritional Survey of British Adults (1986/7 data – first published in 1990) and from the OPCS ad hoc surveys of drinking habits.

E.9 These sources show that although there has been a strong trend towards purchasing "healthier" forms of food such as skimmed or semi-skimmed milk, the national diet differs from that recommended in several major respects:

FATS – over 85% of people are eating more than the recommended levels of fats – particularly saturated fatty acids

SALT – overall intakes of salt are needlessly high and contribute to raised blood pressure

ALCOHOL – one in four men, and one in twelve women, are drinking more than the recommended sensible drinking limits.

E.10 Significant risk factors for a variety of diseases, including CHD and stroke, include:

OBESITY/OVERWEIGHT – Obesity is increasing in both men and women – in 1986/7 12% of women and 8% of men were obese, compared to 8% and 6% respectively in 1980. In addition, overweight is common – 37% of men and 24% of women in 1986/7.

HIGH BLOOD CHOLESTEROL – In 1986/7 about two thirds of the population had blood cholesterol levels above the desirable range. Levels were higher in those eating a high proportion of saturated fatty acids and in those who were obese or overweight.

RAISED BLOOD PRESSURE – Raised blood pressures are associated with obesity and overweight, excessive alcohol consumption and with unnecessarily high salt and low potassium intakes.

E.11 It is clear that many people could improve their dietary habits, thereby reducing the burden of diet-related ill-health. The principal means being used to bring about change are of two main types:

- education, advice and information about the need for balanced diets as part of a healthy lifestyle, and about the risk of alcohol misuse and sensible maximum levels of consumption;

- encouraging shops and catering establishments (both in the public and private sectors, including those in hospitals, schools and other institutions) to offer a range of foods which enables people to make healthy eating choices, and to make alternatives to alcohol routinely available.

SUGGESTED TARGETS

E.12 An unbalanced diet often acts in combination with other elements of an unhealthy lifestyle. It would be possible to target the three significant risk factors mentioned. For obesity, it is important to reverse the trend of recent years. The target proposed would reduce the prevalence of obesity to its level at the start of the 1980s.

E.13 Both high blood cholesterol and raised blood pressure are linked with obesity. In the case of high

blood cholesterol, it is not proposed to set a separate target as the same objective would be served by a target reduction in obesity, together with a specific target for intake of total fats and saturated fatty acids. Similarly raised blood pressure would in part be addressed by targets for obesity and for alcohol consumption. Raised blood pressure has also been discussed in Annex B (stroke) where it is suggested that targets might be developed for early detection and treatment.

E.14 For the main nutrients, possible targets are linked and could be expressed in various ways. Indeed COMA is reviewing its findings on diet and cardiovascular disease and this could lead to some adjustment. The proposals below represent broadly halfway to achieving the COMA recommendations on fats. For total fats, this may be an ambitious target, since there has been little change in recent years in the proportion of total energy derived from fats.

E.15 COMA has not set quantified figures for the consumption of sugars, complex carbohydrates, fibre and salt, although it commented that consumption of salt was needlessly high. The report of COMA's review of recommended daily amounts which is expected soon may address some of these issues. For this reason, no targets are suggested here. Targets for dental health are discussed in Annex H (Health of Pregnant Women, Infants and Children).

E.16 The target for alcohol consumption could be related to the recommended sensible drinking limits or to heavy consumption. The latter would concentrate on the group most at risk, but for positive good health it is important to keep within the sensible drinking limits.

E.17 The specific targets proposed for the year 2005, on which the Government would welcome comments, are as follows:

- **the proportion of the population who derive less than 15% of their food energy from saturated fatty acids should be at least 60%**
- **the proportion of the population who derive less than 35% of their food energy intake from total fat should be at least 50%**
- **the proportion of obese adults should be 7% or less**
- **the proportions drinking more than the sensible limits of alcohol should be fewer than 1 in 6 in men and 1 in 18 in women.**

Physical Activity

INTRODUCTION

F.1 Appropriate physical activity or exercise, like food and sleep, is a necessity for healthy living. It also helps to prevent heart attack, to maintain a healthy weight, to strengthen the bones, and to preserve independence in the elderly and people with a disability.

F.2 Different forms of activity particularly benefit different parts of the body. To prevent obesity, any form of physical activity is helpful; for bone strength the activity has to involve weight bearing as in walking; to protect the heart the exercise has to be regular and aerobic, using the big muscles of the body more vigorously than is customary, as in brisk walking, cycling, and swimming.

F.3 Unfortunately, most people do not have enough of the right kinds of exercise. However, surveys suggest that participation in sports and physical activity is increasing slowly. In Great Britain as a whole the percentage of adults participating in sports, games and physical activity in 1988 was 33%. Within that there are wide variations between different groups of the population. Women are less likely to be physically active than men, and participation decreases with age.

OBJECTIVE

F.4 To improve the health and well-being of the nation through appropriate physical activity.

SCOPE FOR MEETING THIS OBJECTIVE

F.5 Encouragement of physical activity and exercise has a central place in the promotion of healthy living:

- Physical Education is now a compulsory curriculum subject for all children aged 5-16, which will help to establish early habits for physical activity for future health;
- the Sports Council (the channel for Government's own funding of sport) pursues a policy of encouraging participation in sport and promoting better provision of facilities. It has set itself specific targets for increasing the percentage of women and young people participating in sport;
- the Department of Education and Science and the Department of Health are committed to working together to ensure good coordination between local health oriented initiatives and efforts by sports clubs and local authorities to promote greater participation;
- physical activity has formed a part of many of the Health Education Authority's programmes – including "Look After Your Heart" and "Health in Old Age";
- Initiatives encouraging participation are also run by many bodies, including local authorities, employers and employee organisations, voluntary agencies and community groups.

POSSIBILITY OF SETTING TARGETS

F.6 There is, however, a lack of data in this area. More needs to be known both about current levels of participation in physical activity, exercise and sport and current levels of fitness.

F.7 In 1990, to help improve the available information, the Allied Dunbar National Fitness Survey was launched, funded jointly by the Department of Health, Health Education Authority, the Sports Council and Allied Dunbar This national survey, which includes a

physical appraisal, will provide "benchmark" data on participation and the effectiveness of different types of exercise. Results will be available later this year.

F.8 The Government will be looking closely at the findings of the survey and in the light of these will consider possible targets. Physical activity will then be a prime candidate for inclusion as a key area in the future development of the strategy. It may permit detailed proposals for all sections of the population aged 16 and over, to improve the health and well-being of the nation through regular physical activity.

Prevention of Accidents

BURDENS

General

G.1 Accidents are a major cause of death and serious ill-health. They are the most common cause of death in people under 30. They account for something like 13% of all years of life lost under age 65 years, and 7% of NHS expenditure. Over the last 20 years there has been a downward trend in accident deaths at all ages. *Figure G1* shows this trend for selected age groups. A further reduction in the number and severity of accidents would make an important contribution to the prevention of premature death and disability, as well as reducing the demands made of the NHS – not only accident and emergency services, but also primary care and rehabilitation services.

Accidents in the home

G.2 Accidents in the home are the biggest single cause of injury. Each year about 5,000 people die and around 3 million need medical attention following accidents in the home. Although there has been a welcome reduction in the numbers of deaths from home accidents – down from well over 7,000 in 1986 to a little over 5,000 in 1988 – accidents needing medical attention remain stubbornly high.

Road traffic accidents

G.3 In 1989 more than 4,500 people died on England's roads. In Great Britain as a whole some 60,000 people are seriously injured each year and 270,000 slightly injured. Costs to the NHS are in excess of £175 m each year.

Accidents at work

G.4 Seen over the long term the trend in accidents at work is encouraging; fatal injury rates have fallen by two thirds since the early 1960s and by a half since the early 1970s, with employee fatalities generally static in the latter half of the 1980s. In 1988–89, there were 730 fatal accidents attributable to work activities. Further decreases are likely as a result of forecast shifts in employment away from high risk industries. However, major injury rates are still rising in some sectors.

Children

G.5 Children are particularly vulnerable. Accidents are the commonest cause of death among children over the age of 5 and they cause one child in six to attend a hospital Accident and Emergency department every year. Road accidents account for about a quarter of all deaths among schoolchildren and about two thirds of all accidental deaths in the same group.

OBJECTIVE

G.6 To reduce the number and severity of accidental injuries.

SCOPE FOR MEETING THIS OBJECTIVE

G.7 In theory, at least, all accidents should be preventable. Action ranges from legislation, to improved engineering and design, improvements in living and working environments, educational initiatives, and, in the end, increased awareness and carefulness of individuals. The range of those with the opportunity to contribute is equally wide – accident prevention is *par excellence* an example of an area where the best results are achieved by cooperation and collaboration.

Alcohol and accidents

G.8 A high proportion of accidents are attributable to the misuse of alcohol. It is estimated that alcohol is a

factor in something like 25% of all deaths in road traffic accidents, 40% of all deaths from falls, 40% of all deaths in fires and 15% of all drownings. The Government is committed to reducing alcohol-related harm in all its forms, and Ministers from all Departments with an interest in the use and misuse of alcohol meet regularly to coordinate policy and initiate action. In 1989 the Department of Health significantly increased its grant to the Health Education Authority to enable it to raise public awareness of the dangers that result from alcohol misuse and to encourage sensible drinking. A number of initiatives have recently been launched to expand and improve services for problem drinkers.

G.9 A range of drugs (both legally prescribed and deliberately misused), particularly sedatives and tranquillising drugs, also impair the performance of skilled tasks, especially when combined with alcohol, and may therefore lead to accidents.

Legislation

G.10 Legislation, backed by effective enforcement, can set and maintain standards of safety. Examples include:

- The Consumer Protection Act 1987 which provides a strong, yet flexible, legal framework to protect consumers from unsafe consumer goods, and is backed up by a range of regulations covering specific products.

- Regulations introduced in 1989 requiring drivers and passengers travelling in the front seats of cars to wear seat-belts have saved some 200 lives and 7000 serious injuries a year. Regulations requiring children to wear rear seat restraints where fitted were introduced in 1989 and this requirement will shortly be extended to adults.

TRENDS IN ACCIDENTAL DEATHS

ENGLAND 1969 – 1989*

*DISCONTINUITY BETWEEN YEARS 1978 AND 1979 DUE TO CHANGE IN CODING
DATA FOR 1981 AFFECTED BY INDUSTRIAL ACTION BY REGISTRATION OFFICERS.
▲PERCENTAGE CHANGE FROM 1969 TO 1989

SOURCE: OPCS (ICD E800-E949)

figure G1

- The 1974 Health and Safety at Work Act puts responsibility to take care on those engaged in industrial activity: mainly employers, but also self-employed people and others such as suppliers.

Public awareness

G.11 Law and safety standards are only part of the picture. It is also essential to change people's attitude to safety and raise awareness of the potential hazards. Education of children about safety is particularly important. Publicity and awareness campaigns are central to any accident prevention strategy. They may either be general or be targeted on particular hazards or groups who are most at risk – for example, the Department of Transport's current high profile child road safety publicity campaign.

The value of collaboration and local initiatives

G.12 Everyone can contribute in some way to accident prevention. The results of accident prevention initiatives can be greatly enhanced when the various people and organisations involved work closely together and learn from each other's experience. There is much to be gained both nationally and locally from a coordinated approach which draws together all those who have a contribution to make, including Government, industry, employers, local authorities, schools, health services, voluntary groups, community groups, consumer organisations, and individuals themselves.

G.13 Recent Government initiatives which exemplify and encourage such an approach include:

- "Approaches to Local Child Accident Prevention (ALCAP)" published by the Child Accident Prevention Trust on behalf of the Department of Trade and Industry and the Health Education Authority.

- "Children and Roads: A Safer Way", launched in May 1990 by the Department of Transport in conjunction with the Department of Education and Science and the Department of Health, which aims to provide a focus for concerted action to reduce child road casualties.

Role of the health services

G.14 The NHS deals with both the immediate and long-term consequences of accidental injuries. It has a legitimate interest in the prevention of accidents and an important role to play.

- It collects and provides vital data on the incidence and effects of accidents.

- It is a source of expertise on accidents – locally the NHS is in a very good position to identify the scale and nature of problems that need to be tackled.

- It can contribute this expertise to collaborative initiatives with other agencies.

- Health service professionals, including midwives, health visitors and GPs, have opportunities to advise and influence individuals on safety.

G.15 Last year the Government commissioned from the Health Education Authority a report on how best the NHS could contribute to improving child road safety. This report, to be published later in 1991, should help to clarify and develop the opportunities open to the NHS.

POSSIBLE TARGETS

G.16 Effective approaches to accident prevention are well established in this country and continue to be developed and refined. Systems for collecting information

about accidents and their effects are also well developed, although there is of course significant scope for further development, particularly in integrating the various existing sources of information. There are consequently considerable opportunities for the use of specific and meaningful targets to focus and direct action.

G.17 Accident prevention is a diverse subject, and approaches to it both nationally and locally must reflect that. **However, the Government would welcome views on whether there would be advantage in setting broad national targets for accident prevention.** These might act as a tangible expression of the widely shared commitment to accident prevention which already exists, and as a goal to be worked towards together.

G.18 The WHO European target for accidents is that **by 2000, death from accidents in the Region should be reduced by at least 25% from 1980 levels through an intensified effort to reduce traffic, home and occupational accidents**.

G.19 From 1980-89, accident mortality in England fell by some 24%, suggesting that the WHO target will be exceeded easily. This is despite the fact that mortality from all causes of injury and poisoning in England is already one of the lowest in Europe (though this does not apply equally to all categories of accidents).

G.20 There are therefore good reasons to think that targets could well be set which were more exacting than the WHO target. The Government has already adopted such an approach in relation to road traffic accidents where it has set itself the target of reducing road casualties by one third by 2000 (using the average 1981–5 levels as a baseline).

G.21 The Government would welcome views on a target or targets that might usefully be set:

- should they look only as far as 2000, or would long-term development be better served by looking beyond that date?
- the indicator for the WHO target is mortality. What scope would there be for using other indicators, such as measures of temporary or permanent injury and morbidity (eg long absence from work, length of stay in hospital)?
- should targets be for the population generally, or for specific population groups (eg children, elderly people), or should both approaches be used?

Health of Pregnant Women, Infants and Children

INTRODUCTION

H.1 It has long been recognised that the health status of pregnant women, infants and children are important indicators of the general state of health of any population. The WHO "Health for All by the Year 2000" programme and the recent United Nations World Summit for Children, in which the UK participated, have both set objectives for these groups. The health of pregnant women influences the health of their babies, and fetal and infant health is one of the main determinants of health in childhood and later in life.

H.2 The vast majority of births in England result in healthy babies, but there is no room for complacency about the remaining levels of morbidity and mortality amongst both infants and mothers. Infant mortality (to age 1) at 8.4 per 1,000 live births is at its lowest level ever, but better rates have been achieved overseas and the average masks significant variations within England.

H.3 *Figure H1* shows the distribution of causes of death in newly-born infants (neonates), other infants and children aged 1-4 and 5-14. In younger children the principal causes of death are accidents and congenital abnormalities. In older children, accidents and cancers are the principal causes of death. In both groups respiratory diseases are the most common reason for consulting a GP and the most common cause of hospital admission.

OBJECTIVE

H.4 To reduce preventable death and ill-health in pregnant women, infants and children.

SCOPE FOR MEETING THIS OBJECTIVE

(a) Mothers and babies

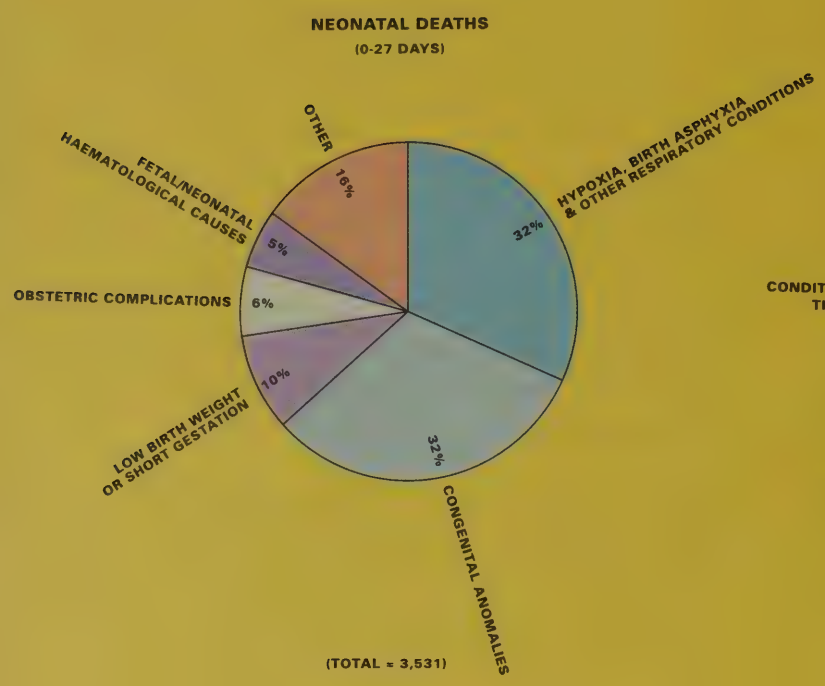
H.5 The scope for safeguarding and improving the health of mothers (before, during and after pregnancy) and of babies includes:

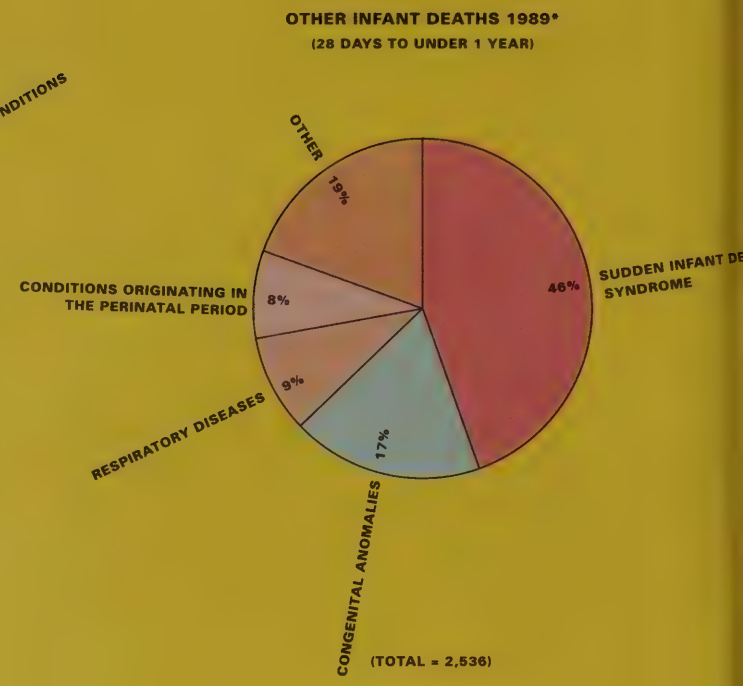
- adoption of a healthy lifestyle – in particular good nutrition and avoidance of both smoking and more than minimal alcohol consumption during pregnancy;
- effective family planning services for those men and women who wish for this;
- protection against infectious diseases (eg rubella);
- high quality maternity care services (tailored where appropriate to the needs of particularly vulnerable groups such as unsupported mothers and certain ethnic minorities);
- good infant nutrition;
- improving general socio-economic and environmental circumstances, in particular quality of housing;
- health education and promotion (about all of the above).

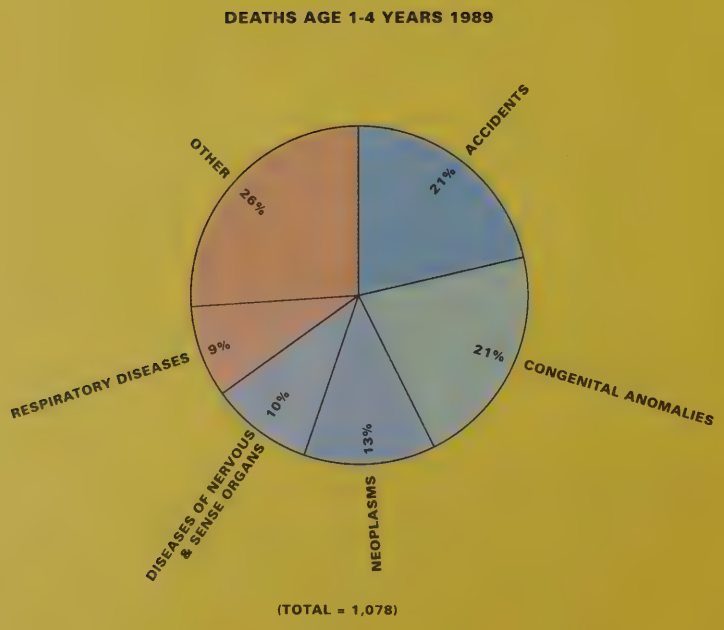
H.6 Healthy lifestyles contribute both to the general health of pregnant women and to that of their babies. Women should aim to maintain a nourishing and varied diet not only from the earliest days of their pregnancy, but even from before they are pregnant. An increased calorie intake should be avoided, as it is not necessary and contributes to obesity. Vegetables and fruit are particularly important for the health of both mother and baby. On the other hand, maternal smoking, addictive drug use and excessive alcohol intake during

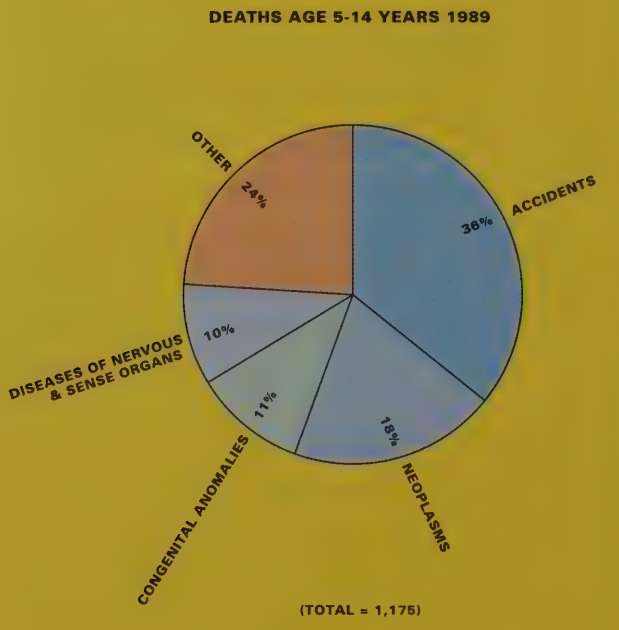
DISTRIBUTION OF MAJOR CAUSES OF DEATHS IN CHILDREN

ENGLAND AND WALES









*A NEW NEONATAL DEATH CERTIFICATE WAS INTRODUCED IN JANUARY 1986, FROM WHICH IT IS NOT POSSIBLE TO ASSIGN AN UNDERLYING CAUSE TO DEATHS UNDER 28 DAYS

SOURCE: OPCS

figure H1

pregnancy all carry risks for unborn children. (See Annex D on smoking.)

(b) Children

H.7 The scope for safeguarding and improving children's health includes:

(i) For younger children

- immunisation against childhood diseases;
- early detection of congenital and acquired abnormalities including impairments in hearing, vision, growth and development;

(ii) For older children

- promotion of healthy lifestyles;
- prevention (particularly through education) of smoking and misuse of alcohol and drugs;

(iii) For all children

- accident prevention and safety education;
- improvements in the quality of the environment, particularly housing;
- avoidance of smoking in the household;
- prevention, identification and treatment of emotional and behavioural problems;
- prevention of dental decay.

POSSIBLE TARGETS

H.8 There are so many determinants of the health of pregnant women, infants and children that it cannot be encompassed by a single target. However, the Government suggests that there is scope for consideration of a number of specific targets:

- reduced stillbirths and deaths in infancy;
- improved hospital care during labour;
- increased breastfeeding;
- reduction in dental caries;

in addition to those on

- childhood immunisations – see Annex L.

H.9 Suggested targets in other areas will have consequences for the health of children. Some will be directly applicable to children as much as adults (eg accidents, diabetes and asthma). In other areas the effects of targets will be less direct or have both direct and indirect consequences – for example the adoption of the healthy lifestyles required to meet targets for reducing coronary heart disease and stroke should improve the health of pregnant women and mean fewer children adversely affected by maternal smoking (and later passive smoking), and more children benefiting from a healthier diet during childhood.

(a) Stillbirths and deaths in infancy

H.10 While the infant mortality rate in England may be at its lowest ever level, there is no room for complacency. Key issues remain:

- significant geographical and social class variations;
- levelling off in the rate of decline;
- the continued prevalence of low birthweight babies due to avoidable factors such as maternal smoking;
- the number of deaths attributable to Sudden Infant Death Syndrome.

H.11 The Government has launched several initiatives to address these issues. They include a requirement that Regional Health Authorities conduct epidemiological

surveys to investigate the patterns and trends of stillbirths and neonatal deaths in their populations. It is also considering the introduction of a national confidential enquiry into stillbirths and deaths in infancy, which would seek to identify ways in which the risk of death might be reduced.

H.12 The Government believes that these investigations will be of considerable value in increasing understanding and prevention of stillbirths and infant deaths. One consequence of this increased understanding will be a greater ability to set appropriate targets in the field. The Government believes that such targets would be valuable. In order to relate these most effectively to actual circumstances, targets should not be national, but rather be set locally in the light of results from the epidemiological surveys and in due course the confidential enquiry. **The Government suggests that an appropriate ambition in this field would be that all Regional Health Authorities (and in turn their District Health Authorities and Family Health Services Authorities) should by 1993 have established for themselves targets for reductions in stillbirths and infant deaths (with, possibly, separate targets within that for deaths from different causes).** Regional Health Authority targets will need to be agreed with the NHS Management Executive.

(b) Low birthweight

H.13 Infants of low birthweight are born too small or too soon, or both, as in multiple pregnancies. They are more likely to die or be ill because of conditions which are associated with low birthweight. In England it is probable that preterm birth is the main cause of low birthweight, but sometimes this is the result of early delivery in the interests of the baby.

H.14 Maternal smoking is a high risk factor for small growth, and a lesser one for preterm birth. Interventions which reduce maternal smoking reduce low birthweight and mortality. (Annex D, paragraphs D.11 and D.12 also discuss smoking during pregnancy.) Many cases of preterm birth, however, cannot be explained and this is a priority for research. There are other interventions to prevent preterm labour, to delay delivery and to reduce the risks of the preterm infant.

H.15 It is difficult to quantify targets for low birthweight, but it is proper to direct attention to maternal smoking, together with interventions of known effectiveness which diminish the consequences of preterm labour or birth.

(c) Maternal deaths

H.16 There has been a substantial reduction in deaths in pregnancy, childbirth and the puerperium. Between 1955-7 and 1985-7 maternal deaths in the UK fell from 67.1 to 7.6 per 100,000 births. The number of maternal deaths is now so low that the total in an individual year is likely to be too small to provide a reliable indicator of trend. However, the aggregated data over the three year periods covered by reports of the Confidential Enquiry into Maternal Deaths (CEMD) remain an important indicator. The CEMD shows that preventable deaths do still occur, and the recently published CEMD report on Maternal Deaths in the UK 1985-87 included a recommendation that every consultant maternity unit should have a consultant obstetrician and anaesthetist readily available whose main priority was to oversee the labour ward. The availability of staff with this level of experience would offer scope for improving the management of many obstetric emergencies.

H.17 The Government suggests that an appropriate target in this field would be for all Regional Health Authorities to have reviewed arrangements in consultant

maternity units by 1993 in the light of the recommended level of cover.

(d) Breastfeeding

H.18 There is no doubt that breastfeeding is the best means of giving infants a healthy start to life. It is natural and provides not only the amount and balance of nutrients for healthy growth and development but also protects against infection and allergy.

Possible targets might be:

- **to increase the proportion nationally of infants who are breastfed at birth from 64% in 1985 to 75% by 2000;**

- **to increase the proportion of infants nationally aged six weeks being wholly or partly breastfed from 39% in 1985 to 50% by 2000.**

(e) Child health

H.19 Suitable targets for child health surveillance and health promotion present themselves less obviously. Given improved understanding of the problems and effective measures that can be taken to address them, areas where target setting might in future be desirable would include:

- prevention and reduction of ill-health caused by respiratory diseases (including asthma – see Annex O);

- the early diagnosis of impairments of hearing, vision, growth and development;

- improved sexual health, eg reduction in pregnancies below the age of 16;

- the prevention of behavioural disorders in children.

(f) Dental caries

H.20 In recent years there have been great improvements in the dental health of children. Dental decay, however, remains one of the most common childhood diseases, causes pain and discomfort, affects well-being and appearance, and is a prime example of preventable morbidity – there is no clinical reason why dental decay in children could not virtually be eliminated.

H.21 The chief causes of dental decay are diet (particularly dietary sugars) and poor oral hygiene. Changes in these together with the use of fluoride toothpaste and the effects of fluoridated water can all reduce the incidence of decay. Health education and dental care also have important roles. The new contract for family dentists, introduced in October 1990, should encourage preventive care in the General Dental Service, backed up by the screening and residual treatment role of the Community Dental Service.

H.22 There continues to be an overall downward trend in the incidence of dental decay in 12-year-olds. The 1983 decennial national survey of child dental health reported that, on average, 12-year-olds in England had 2.9 decayed, missing or filled permanent teeth. Studies carried out in 1988/89 by most District Health Authorities suggest a further improvement since 1983, but also significant regional variations, with the most serious problems in England occurring in North Western and Mersey Regions.

H.23 The WHO dental health targets for 2000 include **". . . 12-year-olds to have, on average, not more than 3 decayed, missing or filled permanent teeth".** This has already been achieved in England as a whole. With the help of oral health education and the preventive care of the dental profession, it should be possible to achieve a much more ambitious target. **The Government considers**

that such a target might be that by 2003, nationally 12-year-olds should on average have no more than 1.5 decayed, missing or filled permanent teeth. Regional and sub-regional targets are particularly appropriate in this area, as some regions will be able to set even more challenging targets, while others have more severe local problems.

DIABETES

BURDENS

I.1 Diabetes mellitus manifests itself in three main forms:

- insulin dependent diabetes mellitus – IDDM;
- non-insulin dependent diabetes mellitu – NIDDM;
- gestational diabetes (diabetes of pregnancy).

I.2 Estimates indicate that the prevalence of clinically diagnosed diabetes in England is between 1% and 2%, ie about half a million people. Estimates from surveys suggest that between 40% and 50% of diabetes may be undetected. It is estimated that between 4% and 5% of total health care expenditure is spent on the care of people with diabetes (including the cost of dealing with its complications).

I.3 The prevalence of diabetes is higher in certain sub-groups of the population, such as the elderly and people of Asian and Afro-Caribbean origin. For those of Asian origin the prevalence of NIDDM is nearly five times that in comparable European populations.

I.4 The incidence in children and adolescents (those aged 0-19) in England is between 10 and 15 new cases per 100,000 population each year, and this appears to be increasing.

I.5 The main complications of diabetes are cardio-vascular disease, renal disease, visual impairment and neuropathy. People with diabetes are at a greatly increased risk of death from coronary heart disease and stroke and more than one in every 1000 known diabetic people will develop end stage renal failure. Diabetes can cause visual impairment, although it is not known what proportion of people with diabetes will go on to develop visual complications. The commonest problem arising from diabetic neuropathy is reduced sensation in the feet which can rapidly lead to ulceration and infection, and even amputation.

I.6 It is difficult to quantify the number of deaths to which diabetes has contributed, because diabetes is not always mentioned on death certificates as a contributory cause of death, particularly amongst younger age groups.

OBJECTIVE

I.7 To reduce death and ill-health caused by diabetes, principally by ensuring the effective provision of services.

SCOPE FOR MEETING THIS OBJECTIVE

(a) Prevention

I.8 IDDM is caused by a failure in the production of insulin by the pancreas. NIDDM is caused by impaired production of insulin and/or impaired utilisation. Each form has a genetic component, but obesity is an additional risk factor for NIDDM, which means there is scope for prevention of that type of diabetes through the adoption of healthy lifestyle and maintenance of a healthy weight.

(b) Treatment

I.9 There is no evidence that a national screening programme for diabetes would be cost effective. Screening of high risk groups is, however, effective. Identifying people with diabetes allows the management of the disease to reduce the incidence of complications and improve the quality of life.

I.10 To avoid the complications, blood glucose must be controlled and maintained within normal levels. In the

case of IDDM this involves the regular injection of insulin. For NIDDM, treatment is usually by a carefully controlled diet, often in conjunction with oral hypoglycaemic drugs. All people with diabetes require a carefully controlled diet and regular checks of the level of glucose in their blood or urine to monitor their condition. It is also important to check blood pressure regularly and to look for the early signs of circulatory problems and complications such as ulceration of the feet, retinopathy or renal disease.

I.11 There is significant scope for reducing the impact of diabetes. Of particular importance are:

- collaboration between purchasers of services and providers, and between purchasers themselves (Family Health Services Authorities, District Health Authorities and GP fund holders). Shared policies are needed for diabetes, covering diagnosis, referral and other clinical decisions that have to be made to provide services for people with diabetes;
- the availability of comprehensive services, involving amongst others diabetologists, general physicians, geriatricians, ophthalmologists, opticians, specialist and general nursing services, dieticians, and chiropodists;
- shared treatment plans drawn up between patients and their doctors.

POSSIBLE TARGETS

I.12 The nature of diabetes is such that targets have to be focused on the complications, which must be considered individually.

I.13 In October 1989 organisations from all European countries and WHO met with diabetes experts and the International Diabetes Federation in St Vincent, Italy. The St Vincent Declaration agreed the following targets:

- **reduce new blindness due to diabetes by one third or more**
- **reduce by one half the rate of limb amputation for diabetic gangrene**
- **achieve a pregnancy outcome in diabetic women that approximates to that of non-diabetic women**
- **reduce the numbers of people entering end-stage diabetic renal failure by at least one third**
- **cut morbidity and mortality from coronary heart disease in people with diabetes by vigorous programmes of risk factor reduction.**

I.14 **The Government would welcome views on the feasibility of setting such targets.** Although the St Vincent Group is working on the development of baseline data for these targets, the information necessary for monitoring them is not currently available in England. Some of it should be available in the fairly near future, the remainder will take some time to develop. It is expected that the first two areas in which the necessary data are available will be pregnancy outcome and end-stage renal failure.

I.15 Additionally, it is known that certain service activities are likely to produce good health outcomes. Until it becomes possible to use outcome measures such as those of the St Vincent Declaration, these activities could be measured as a proxy for health outcomes. Examples are:

- the proportion of GP practices within a Family Health Services Authority area who follow protocols

agreed locally between hospital clinicians and primary care staff for providing services to people with diabetes;

- the proportion of people with diabetes screened, within a given period, for the long term individual complications of diabetes;

- the proportion of people with diabetes who have received a free NHS eye test in the preceding year. (This should be superseded in time by a specific diabetic retinopathy screening programme for all those at high risk. Work is taking place on this within the Department of Health.)

The level of each target will need to be agreed by consultation between the Government, NHS and other interests.

Mental Health

BURDENS

J.1 Mental disorders are a major cause of morbidity accounting for 14% of reported days off work. They account for 23% of NHS in-patient costs and 25% of pharmaceutical costs. The wider costs of mental illness are huge. The total direct and indirect costs (including lost production) of depression and anxiety have been estimated at up to £4.6 billion a year and of schizophrenia at up to £2.7 billion a year.

J.2 Most people with mental illness are not in hospital. Of every 1000 people, 230 attend their family doctor each year with symptoms of mental illness but only 21 are referred to hospital. Over six times as many people attend consultant psychiatrists as outpatients as are inpatients.

OBJECTIVE

J.3 To reduce the level of disability caused by mental illness by improving significantly the treatment and care of mentally disordered people.

SCOPE FOR MEETING THIS OBJECTIVE

J.4 Against a background of steadily improving medical and nursing care, the arrival in the 1950s of drug treatments giving effective relief from the symptoms of major illnesses such as schizophrenia had a dramatic effect in improving the quality of life of people with severe mental illness enabling the great majority of patients, who previously would have faced long-term care in hospital, to be treated in the community. There remains considerable scope for further improvement in treatment with the aim of reducing the level of disability caused by mental illness.

J.5 The 1975 White Paper "Better Services For the Mentally Ill" set out the Government's commitment to move the services away from their traditional base in large remote institutions into a district based service with a balance of hospital and community based services as near as possible to where people live. Experience since 1975 has demonstrated the essential strengths of the White Paper's approach when this has been properly implemented. The 1989 White Paper "Caring for People" reaffirmed that approach and described the main elements of a modern district based service.

J.6 Much has been learnt since 1975, particularly the requirement to pay close attention to the needs of those with long-term illness and to ensure that local services, including the need of some seriously disabled people for "asylum", are properly developed before the older hospitals are closed. The new Care Programme approach supported by the Mental Illness Specific Grant to local authorities underlines the commitment that there must be effective plans tailored to the needs of every patient needing continuing specialist care in the community. There is also a firm commitment that Ministers will not approve any hospital closure until they are satisfied that adequate alternatives have been developed.

J.7 Effectively implemented, new style services offer a much higher quality of life to mentally ill people and a service which is more appreciated by their families than is possible in the traditional large and often remote mental hospital. Moreover these hospitals represent increasingly poor value for both patients and for the NHS resources invested. Of the £1.5 billion spent by the health service on the specialist mental illness

service, over half supports the 40,000 beds in the old traditional hospitals. The vast majority of patients requiring specialist care who are treated in the community, some as seriously ill as those in the old hospitals, are supported by less than half the available resources. Not surprisingly services to those in the community are sometimes experienced as less than satisfactory. There is a clear and urgent need to realign the resources tied up in the old hospitals into more appropriate services.

SUGGESTED TARGET

J.8 Some progress has been made in developing both needs assessment and appropriate outcome measures for mental health. However, there is at present no straightforward and objective way of describing, aggregating or monitoring outcomes of care, nor any agreement on clear and reliable measures which could confidently be used as proxies for outcome measures. The work which has started in this area needs to be followed up vigorously to ensure that progress is made. However, in the present state of knowledge it is unrealistic to set health outcome targets for these services.

J.9 Experience to date does however suggest that there is clear benefit to patients and their carers from the transition to a district based service and that this gain is likely to be achieved most effectively as a result of a planned closure programme rather than a gradual shift from one type of service to another. **A single measurable target over the next decade would be to realign the resources currently spent on specialist psychiatric services into district based services, thereby allowing many of the remaining 90 large psychiatric hospitals – relics of an outmoded pattern of care – to be closed before 2000.** But it would be essential that successful achievement of this target was not measured by hospital closures alone. It would be necessary to develop assessable parameters related to the provision of appropriate district based hospital and community services and to their performance. The aim would be to ensure that there were demonstrable improvements in mental health services based, as soon as practicable, on measures of outcome. In the meantime, **the objective should be to reach agreement on measures of structure and process which, taken as a whole, would act as reliable, unambiguous monitors of progress.** What overall target and what measures of progress might be set will need to be discussed with NHS, local authority, professional and other interests.

HIV/AIDS

BURDENS

K.1 HIV/AIDS is arguably the greatest new threat to public health this century. It has been estimated that about 5,000 new cases of AIDS will be reported in homosexual men in England during 1989-93. Predictions for numbers of cases acquired by transmission through heterosexual intercourse and injecting drug use are more difficult, but it is possible that by 1993 over half the new cases could be in these two categories compared with only 7% of reports in the first nine months of 1989.

K.2 By the end of December 1990 there had been a total of 3,817 reported cases of AIDS in England of whom 55% had died. There were 12,985 known HIV antibody positive people of whom 1,099 were female. The figures for known HIV positive people are likely to be substantially less than the true number.

K.3 AIDS cases in homosexual and bisexual men still account for 81% of the total. However, the rate of increase in new cases amongst this group during 1990 was only 46% compared with an 82% increase in cases acquired by heterosexual intercourse during the same year and an even greater increase in the number of people infected by contaminated drug injecting equipment. Cases amongst women increased by 119%, rising from 37 at the end of December 1989 to 81 by December 1990.

K.4 As with AIDS cases, there is evidence of rapid growth in the number of people infected with HIV through heterosexual intercourse. Reports in this group increased by 65% during 1990, compared with 20% for homosexual or bisexual men. Just under half the infected heterosexual people are women.

OBJECTIVE

K.5 To reduce numbers of new cases of HIV and AIDS, primarily by controlling the spread of HIV through education about and adoption of safer sexual behaviour and intravenous drug taking practices.

SCOPE FOR MEETING THIS OBJECTIVE

K.6 The spread of HIV can be limited by the adoption of safer sexual and intravenous drug taking behaviour. There is much that can be done to foster the necessary awareness and behaviour. In addition, though there is no cure, there is some evidence that the early detection of HIV offers some opportunities for treatment which may delay the onset of AIDS.

K.7 The main plank of the Government's strategy to limit the spread of HIV is public education. The Health Education Authority runs national and more targeted campaigns in close co-operation with the health departments and Government generally.

K.8 The national campaign is complemented by educational initiatives at local level for which the NHS has been given funding. The recently appointed District HIV Prevention Co-ordinators have a key role in pulling together the work of statutory, voluntary and community agencies. Co-ordinators have also been asked to mobilise and develop the preventive role of genito-urinary medicine (GUM) and other health services, and to work with local authority education workers to develop HIV educational work in schools and colleges.

K.9 As well as cases of HIV/AIDS, some 560,159 new cases of other sexually transmitted diseases (STDs) were seen in GUM clinics in England in 1988. Whilst

other STDs have tended to be overshadowed by HIV/AIDS they are nevertheless important and disabling in their own right and may facilitate the spread of HIV. Their prevention should be considered alongside HIV/AIDS. Health education and other preventive activities are the key to reducing STDs. In addition the recent Monks report has made a number of recommendations which should result in improved services for those seeking confidential advice and treatment for HIV and for other sexually transmitted diseases from GUM clinics.

POSSIBILITY OF SETTING TARGETS

K.10 An essential first step when looking at the possibility of target setting is improving understanding of the prevalence of the disease. A fuller understanding of the prevalence of HIV will assist service planning and the better targeting of public education campaigns. At present, information is not yet sufficient to allow targets to be set for limiting the spread of HIV.

K.11 To improve the available information, the Medical Research Council, funded by the Department of Health, began a series of anonymised sero-surveys in January 1990. The preliminary results of the first study on women going to antenatal clinics and of attenders at drug misuse and GUM clinics are expected in mid 1991. In time, as these studies become more generalised the results should enable more accurate predictions to be made on the state and geographical distribution of the epidemic in the UK.

Other Communicable Diseases

(a) IMMUNISATION – PREVENTABLE COMMUNICABLE DISEASES

L.1 While communicable diseases are not at present a major cause of death in England they are a significant cause of morbidity, lost working days and economic loss. Furthermore because the incidence of these diseases is now at very low levels due to immunisation there remains a very great potential for ill-health should immunisation rates fall.

L.2 Prior to the development of effective vaccines and of national immunisation programmes, some infectious diseases had a devastating effect on the health of the population, particularly young children. Before 1940 *diphtheria* led to an annual average of 60,000 cases, with 3,000 deaths in England and Wales. As late as the 1950s *poliomyelitis* resulted in an average of 2,800 cases a year, with 320 deaths. *Whooping cough* reached more than 100,000 notification per annum until immunisation was begun in the 1950s, though notifications returned temporarily almost to that level in major epidemics in 1977–79 and 1981–83, when public and professional anxiety about the safety of the vaccine led to a fall in acceptance rates. All these diseases can still lead to death and in many cases permanent disability.

L.3 Meningitis is another important communicable disease. In 1990 (provisional figures) there were 1142 notifications of meningococcal meningitis and 282 notifications of meningococcal septicaemia. There were 165 deaths from all meningococcal infections. Invasive disease from Haemophilus influenzae b infections, especially meningitis, has been increasing, though a vaccine will be introduced in 1992 (subject to licensing and adequate supplies being available). Similarly, pneumococcal infections cause considerable morbidity and mortality, especially pneumonia in the elderly and meningitis in younger people. There are good prospects for more effective vaccines which may be available within the next few years.

OBJECTIVE

L.4 To reduce or eliminate these diseases, principally by preventing their spread.

SCOPE FOR MEETING THIS OBJECTIVE

L.5 The present generally low level of communicable disease rests in part upon the many benefits of the public health reforms of the 19th and early 20th centuries. Immunisation policy has played a major role in controlling many of these diseases and will play an increasing role in the future. The national surveillance and monitoring systems coordinated by the Public Health Laboratory Service have had and continue to have an important role in supporting communicable disease policy.

L.6 Actions to prevent and control these diseases can be classified as:

- immunisation to protect individuals and also, if sufficient individuals are immune, to break the "chain of transmission" and eliminate the disease;
- effective surveillance to identify cases as early as possible, coupled with out-break control – treating the source and protecting close contacts through immunisation or antibiotic prophylaxis;
- early diagnosis to allow appropriate treatment;
- health education to encourage acceptance of immunisation.

L.7 The national immunisation programme now provides immunisation for young children against seven childhood diseases: diphtheria, tetanus, whooping cough, poliomyelitis, measles, mumps and rubella. This programme is due to be augmented in October 1992 by the addition of a vaccine against Haemophilus influenzae b (Hib), a major cause of meningitis in children under 5 years.

L.8 The programme is supported by

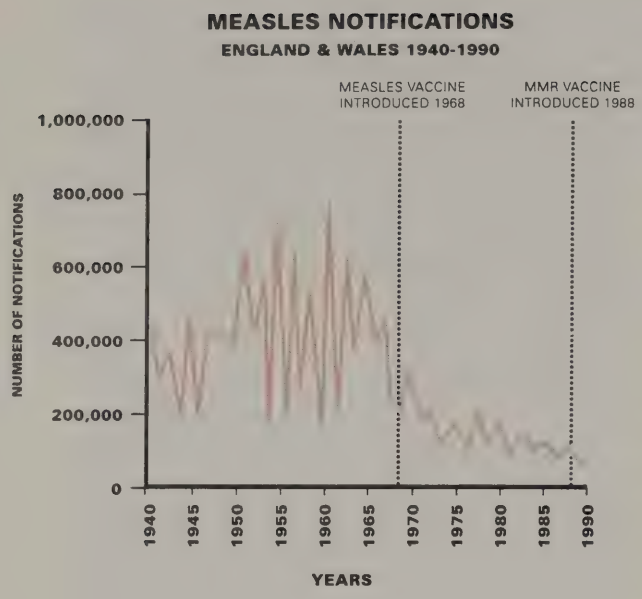
- professional and public information and education campaigns on the benefits and safety of immunisations;
- extensive use of computer services for call-up and recall, and for feeding back immunisation data to service providers;
- use of immunisation coverage targets in the health promotion/disease prevention objectives of Regional Health Authorities;
- appointment of immunisation coordinators to take responsibility for the immunisation programme in all District Health Authorities;
- special payments to GPs who achieve target levels of immunisation coverage in their practices.

POSSIBLE TARGETS

L.9 Targets for immunisation are already well developed and are used effectively in the management of the immunisation programme. Target 5 of the WHO European Region's "Health For All by the Year 2000" strategy states that "by the year 2000, there should be no indigenous poliomyelitis, neonatal tetanus, diphtheria, measles or congenital rubella syndrome in the European Region". Although that target does not include mumps or whooping cough, it is the Government's aim that these should also be eliminated. In 1985 the Government agreed the World Health Organisation's recommendation to aim for 90% coverage of immunisation nationally by 1990, as a step towards elimination.

L.10 Estimates show that the national averages for immunisation coverage for England in February 1991 were 90% for diphtheria, tetanus and polio, 89% for measles, mumps and rubella and 85% for whooping cough. However this will not achieve permanent elimination of these diseases, particularly in the case of whooping cough and measles. The Government has therefore considered the need to revise the national 90% targets. This has been endorsed by the Joint Committee on Vaccination and Immunisation, which advises on all aspects of immunisation, and some health districts have already taken the initiative and set themselves higher targets. **It is the Government's intention, therefore, to set new national targets of 95% coverage by 1995.**

L.11 As indigenous poliomyelitis, diphtheria and neonatal tetanus have already been eliminated, outcome targets for disease reduction for these diseases are unnecessary. Measles elimination will be harder to achieve, although the progress is good, as *figure L1* shows. The World Health Organisation has recommended that by 1995 countries should have achieved a 90% reduction of measles notifications from pre-immunisation levels. This has already been met in England. **The Government therefore suggests a realistic target would be a 90% reduction by 1995 on 1989 levels.**



SOURCE: OPCS

figure L1

(b) HOSPITAL ACQUIRED INFECTION

L.12 Studies in the UK and abroad indicate that approximately 10% of in-patients have an infection contracted in hospital. Although some of these infections are trivial, others complicate treatment of the underlying condition and lead to increased morbidity and mortality. All increase the costs of hospital treatment.

L.13 The long-term objective should clearly be to reduce as far as possible the incidence of these infections. Action to reduce the risk of patients becoming infected will include improvements in medical and nursing practice and arrangements for the management of patients who are particularly vulnerable and infected patients who pose a threat of cross-infection to others. A range of support services may contribute to reducing infection, including cleaning and maintenance services.

L.14 Given the existence of interventions which can reduce levels of infection there is scope for setting targets. These might initially relate to procedures to be adopted. Targets could be set on the basis of what can be achieved through good practice. The surveillance of hospital acquired infections is now considered to be an essential part of medical and clinical audit and experience from this will allow the continuing development of realistic targets in individual units taking into account patient mix and other relevant factors.

Food Safety

(a) FOODBORNE DISEASES

M.1 Food poisoning causes a good deal of illness, though not many deaths. The number of cases notified in England and Wales rose from almost 40,000 in 1988 to nearly 56,000 in 1990. The figures have been increasing since 1982, as shown in *figure M1*. There is undoubtedly an underlying rising trend even though recent concerns about food hygiene are likely to have led to increased reporting. Furthermore many cases are not notified; the Department of Health and the Public Health Laboratory Service are initiating surveys to provide the first ever well founded data on the actual incidence of food poisoning.

M.2 Salmonella isolations in laboratories rose from over 27,000 in 1988 to a little over 30,000 in 1990; cases of campylobacter reported by laboratories rose from nearly 29,000 in 1988 to nearly 35,000 in 1990. There were 61 registered deaths where salmonella infection was given as the underlying cause in 1989, and 2 deaths due to other bacterial causes, neither being campylobacter. Cases of listeriosis recorded in England and Wales fell from 281 in 1988 to 116 in 1990. Death occurs in about a quarter of the cases of listeriosis and the infection can affect the fetus and the new born baby.

M.3 These figures represent considerable morbidity and economic cost, particularly sickness-related absence from work. It is difficult to estimate the full economic cost of this illness, but tangible costs of foodborne infection in England and Wales in 1988 have been estimated as something like £28 million (including health care and investigation costs, lost productivity and associated costs for the family, but excluding the cost to industry of preventive measures such as withdrawing food).

OBJECTIVE

M.4 To reduce death and ill-health resulting from foodborne disease.

SCOPE FOR MEETING THIS OBJECTIVE

M.5 Salmonella and other organisms such as listeria and campylobacter are widespread in the environment. Foreign travel is likely to be a continuing source of infection. The transmission routes of diseases due to these organisms are generally well understood and there is therefore scope for action to reduce the incidence of infection from them. A concerted effort will be needed on a number of fronts:

- All sectors of the food industry will have to improve hygiene standards. For example, an Audit Commission survey in 1990 found that almost 1 in 8 of food premises presented a significant or imminent health risk. The stricter obligations imposed by the Food Safety Act 1990, increased use of quality assurance systems, recently introduced rules about the temperature at which food should be kept, and better training for food handlers should all contribute to higher standards.

- Environmental Health Officers (EHOs) can help by using the new and stronger powers obtained under the Food Safety Act 1990 and by seeking more uniform enforcement. They can also increase their educational and training role.

- Consumers need to be more aware of hygiene problems. A public health education campaign has encouraged consumers to be more aware of the simple guidelines on food hygiene and to take more care in the kitchen.

• The Department of Health and Ministry of Agriculture, Fisheries and Food will continue to provide the necessary statutory framework for preventive action (eg to reduce the incidence of Salmonella enteritidis in poultry flocks); to carry out research and surveillance; and to give general advice. They have set up a steering group to develop surveillance programmes and a new expert advisory committee to interpret surveillance results, identify risks, and give general advice on the microbiological safety of food.

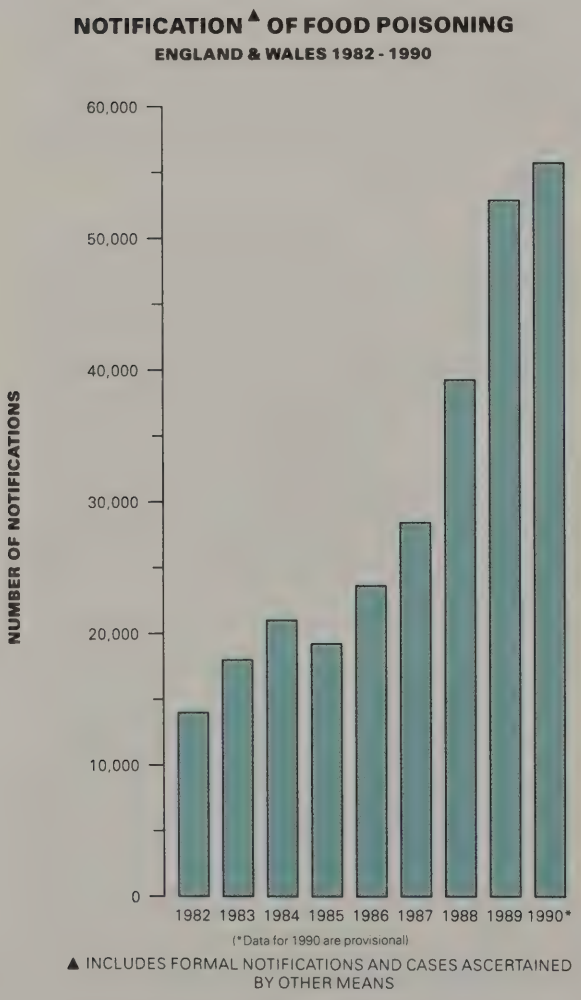


figure M1

POSSIBILITY OF SETTING TARGETS

M.6 The obvious target would be to reduce the incidence of food poisoning by a stated amount at a given date. There is, however, no sound basis for determining a target in this way and it may thus be premature to do so. The results of the Department of Health's current studies, which are intended to give a better idea of the actual incidence of food poisoning in the community, should make it possible to identify target areas for further initiatives. It would however still be necessary to allow for the unpredictable way in which particular organisms can increase or decrease.

M.7 Intermediate measures might be obtained from an analysis of the activities of enforcement officers. From mid-1991 onwards the results of enforcement action will be reported regularly in accordance with an EC directive. When some experience of this has been obtained the possibility of setting targets might be considered. It would also be valuable to look again at hygiene standards in food premises to identify how much progress had been made in improving the situation found by the Audit Commission.

(b) CHEMICAL FOOD SAFETY

M.8 Food supports life by providing nutrients, that is chemicals which can be absorbed and used in the body. Even essential nutrients can however be harmful if taken to excess; and some chemicals may have undesirable effects at levels which could occur in a normal diet.

M.9 There is no easy way of assessing the potential risk to health posed by the presence of toxic chemicals in food. Occasionally, human epidemiological data are available, but usually they are not. In the absence of human data, laboratory animal studies must be used to assess potential hazards and risks.

OBJECTIVE

M.10 To ensure the safety of food supplies by preventing, as far as possible, adverse health effects arising from toxic chemicals in food.

SCOPE FOR ACHIEVING OBJECTIVE AND POSSIBILITY OF SETTING TARGETS

M.11 The potential for ill-health can be reduced by means of research, assessment of risks and, where necessary, regulation or other action.

M.12 Chemicals in food which need safety assessment range from food additives or food contact materials, which can be assessed before introduction and whose presence in food can be relatively easily controlled, to environmental contaminants and natural toxins, which are less easily monitored and controlled. New food chemicals or processes are thoroughly tested and assessed. A long history of human exposure may not of itself however guarantee safety. For the majority of food additives sufficient toxicity data are available to allow judgements to be made about safety. But for food contaminants or natural toxins the problem is one of setting priorities for further research and surveillance in order to fill any gaps in scientific knowledge.

M.13 The Department of Health and Ministry of Agriculture, Fisheries and Food have in place a comprehensive system of surveillance of the chemicals in food so that potential problems can be identified and avoided. Priorities are set for research and surveillance taking into account such factors as:

- length of human exposure;
- frequency of exposure (daily, occasional, etc);
- extent of human exposure, based on known concentrations in food and amounts of food consumed;
- exposure of possible high-risk groups in the population, eg infants, pregnant women, elderly people etc;
- any known data on toxicity;
- in the absence of toxicity data or gaps in the database, assessment of possible toxicity based on knowledge of related compounds.

M.14 Risk assessment, and to some extent regulation, are increasingly being co-ordinated by international bodies such as the EC. There is a need for priority setting in the work of these bodies also, which can help to prevent unnecessary duplication of effort.

M.15 In contrast to foodborne diseases from microbiological sources, the scope for identifying ill-health caused by the chemicals in food using epidemiological data, and consequently the ability to set measurable targets for improvement in human health, is limited. The Government believes that all the necessary measures are being taken, but would be glad to receive views.

Rehabilitation Services for People with a Physical Disability

BACKGROUND

N.1 Rehabilitation is an integral part of medical practice and a major component of specialities such as cardiology and geriatrics. It is also a designated speciality in its own right providing services aimed at the restoration of optimum functioning following illness or injury irrespective of the cause.

N.2 Although in recent times there has been an ever increasing number of people with chronic and multiple disability including those disabled through accidental injury, there is a widespread lack of understanding of what rehabilitation can do to restore functioning. There is a tendency for NHS hospitals to concentrate on the acute phase of care. On discharge, health and social care may be available in the community, but often with the emphasis being on helping to maintain the individual at a lower level of functioning than before his or her illness or injury. Individual and group expectations among those with chronic illness or disability have traditionally been low.

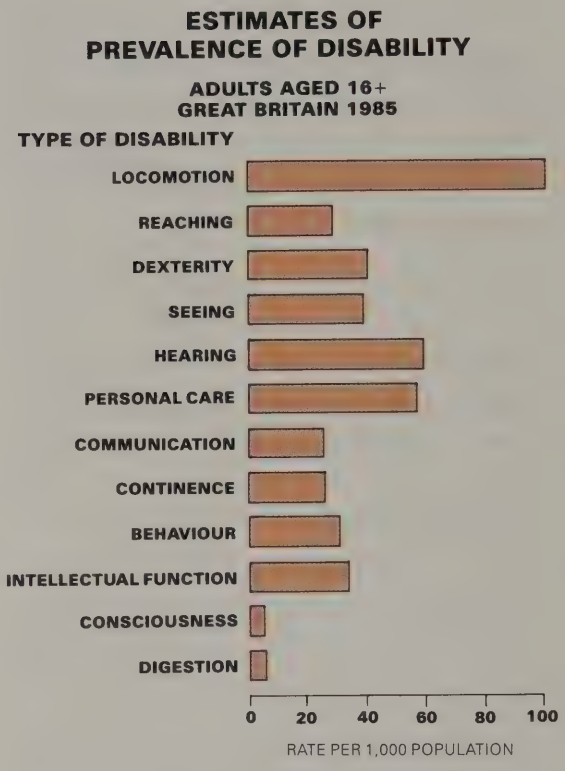


figure N1

OBJECTIVE

N.3 To enable people with physical disabilities to reach their optimum level of functioning.

BURDENS OF DISABILITY

N.4 Few statistics are available regarding the overall effects of disability on premature mortality. Some conditions considerably reduce life expectancy (for example, motor neurone disease). Other conditions, such as paraplegia, were once associated with death soon after injury but now are increasingly expected to have an almost normal duration of life. Many of those who suffer brain injury have little reduction in life expectancy.

N.5 Thanks particularly to the OPCS Survey of Disability there is extensive information available about the effects of physical disability on morbidity. OPCS has estimated that there are over six million people (14% of the total) in the adult population in GB who have one or more significant disabilities. *Figure N1* shows the distribution of the types of disability. Physical disability causes much personal suffering and reduces the quality of life for many people. Physical disability affects the individual, the family, the community and – through economic and other costs – society at large.

N.6 There are no overall figures regarding the cost of disability to the NHS, but these costs are thought to be very high. As long ago as 1982 the cost to the NHS of back pain alone was estimated at more than £156 million. Pressure sores have been estimated currently to cost more than £60 million a year. Some £100 million a year is being provided to run artificial limb and wheelchair services for the coming two years. Many millions of £s are spent on items such as surgical appliances, continence aids and appliances, and drugs.

CURRENT PROVISION

N.7 NHS services for disabled people are provided in hospitals and in primary care. But there has been criticism about the level of provision and the failure to complement or dovetail with services provided by other people. Concern has also been expressed about:

- the shortfall in the number of therapists;
- deficiencies in the provision of aids and appliances;
- the provision of appropriate information to disabled people.

N.8 A Royal College of Physicians report (November 1990) on health services for disabled people showed the proportions of NHS health districts which did not provide any:

	%
• Consultant sessions for assessment and rehabilitation of disabled people	48
• Young disabled units	56
• Special stroke recovery services	66
• Special services for head injuries	73
• Special services for amputees	81

N.9 The report also stated that:

- 53 District Health Authorities provided no training courses on disability;
- in 47% of the District Health Authorities the Community Health Council (CHC) had expressed concern about rehabilitation services in general;
- in 22% of District Health Authorities there had been formal representations by the CHC.

A TIME FOR CHANGE

N.10 1991 provides a unique opportunity for developing rehabilitation because of the integration into the NHS of services formerly provided by the Disablement Services Authority (DSA). Other factors include:

i. the wider debate stimulated by the Royal College of Physicians report and the DSA itself;

ii. the effects of the employment by the NHS as consultants of doctors who formerly worked for the DSA in wheelchair and prosthesis services – these doctors have experience in rehabilitation and can be expected to attract wider responsibilities within the NHS;

iii. the allocation of an additional 15 senior registrar posts in the specialty, and the offer by most Regional Health Authorities to take up these posts over the next few years;

iv. the change in the role of District Health Authorities to purchasers – although this change in itself will not be enough; what will be required is a consensus that they **should be purchasing** rehabilitation services.

N.11 There is a danger that opportunities may not be grasped and momentum may fall away unless:

- there is a clear lead from the centre;
- there is effective monitoring of NHS authorities' performance in purchasing effective and appropriate services.

THE WAY FORWARD AND THE POSSIBILITY OF TARGETS

N.12 Some steps have already been taken. Guidance from the Department of Health has stressed the importance of rehabilitation; a lead Regional General Manager and Regional Director of Public Health have been identified.

N.13 In addition to this, consideration is currently being given to:

- how a model specification for rehabilitation services might be drawn up, piloted and disseminated;
- how take-up of the model by purchasing District Health Authorities might be monitored;
- how the Department of Health can liaise with and encourage the relevant professional bodies in the development of the specialty.

N.14 Because of this, and the diverse nature of disability and rehabilitation, it is considered inappropriate at this stage to propose specific national targets for rehabilitation services. However, suitable targets should be developed in the future to support widespread and effective service provision. It has been decided to set up a small Advisory Group on Rehabilitation to advise Ministers and the Department of Health on these matters. It will act as a focus for views from interested bodies and offer an independent stimulus to further development.

N.15 There is, however, scope in the meantime for Health Authorities to set targets aimed at specific disabling conditions. Examples include pressure sores, incontinence and contractures, but there are many others for which standards should be set.

N.16 Pressure sores in particular have been estimated as affecting 6.7% of the adult hospital population and costing about £60 million per year. They are largely preventable by a district-level multi-disciplinary programme of intervention. **The Government's view is that an annual reduction of at least 5% – 10% in their incidence would be a reasonable target**. Clearly the first task for Health Authorities would be to establish the baseline incidence and prevalence of the conditions to be targeted.

N.17 In respect of incontinence, the Department of Health recognises the importance of effective continence services for elderly and disabled people. It is therefore currently conducting a review of its policies on these services. The aim of this review will be to identify and disseminate good practice.

ASTHMA

BURDENS

O.1 Asthma is a common chronic condition in which the airways narrow easily in response to a wide range of triggers. This may manifest as coughing, wheezing, a sensation of tightness in the chest or shortness of breath.

O.2 It is estimated that there are about 2 million asthma sufferers in the United Kingdom of whom upwards of 700,000 are children and adolescents under the age of 16. Asthma accounts for about 1800 deaths a year and 40% of these occur before 65 years of age.

O.3 There is significant morbidity associated with asthma in terms of lost schooling and sickness absence. More than 5.5 million days of certified sickness absence were recorded in Britain in 1987/88 representing of the order of 7 million actual days lost. The estimated cost of this was some £350 million in lost productivity, £60 million in sickness benefit and something of the order of £400 million to the NHS.

O.4 There seems little doubt that despite the availability of effective preventative therapy the prevalence of asthma as assessed by GP consultation *(figure O1)* and the occurrence of acute asthmatic attacks has been rising. Mortality trends are more complex, although there is some evidence of a rise during the first part of the 1980s. It seems unlikely that the changes can be attributed to shifts in diagnostic labelling (for example from "bronchitis").

OBJECTIVES

O.5 To reduce deaths and ill-health attributable to asthma in the short to medium term by the effective provision of services and in the long term by establishing its aetiology.

SCOPE FOR MEETING THESE OBJECTIVES

(a) Prevention

The causes of asthma are incompletely understood. There are certain well recognised causes of occupational asthma and outside the occupational setting attacks in individuals may be triggered by agents to which they are sensitive. There is thus some scope for reducing the risk of an attack by the avoidance of exposure to such agents. However most cases of asthma are not strongly influenced by external factors so that avoidance of exposure has limited potential.

(b) Treatment

O.7 Effective recognition and treatment of asthma offer scope for a reduction in the mortality and morbidity. Therapy is directed at preventing an attack and should an attack occur at early recognition and effective treatment. An important aim is to minimise side-effects and treatment-induced complications. With those aims in mind a number of treatment protocols have been suggested. Peak flow meters enable individual sufferers to make objective measurements of their own airways function. These meters were recently made available on prescription. There is thus scope for improved management by the individual patient and clinician, for example through the earlier detection of deteriorating airways function and the tailoring of treatment regimes to avoid both under-treatment and over-treatment.

O.8 Collaboration between GPs, clinicians and Health Authorities in order to establish shared policies on access to services, agreements between clinicians and GPs on treatment protocols, and the more wide-spread

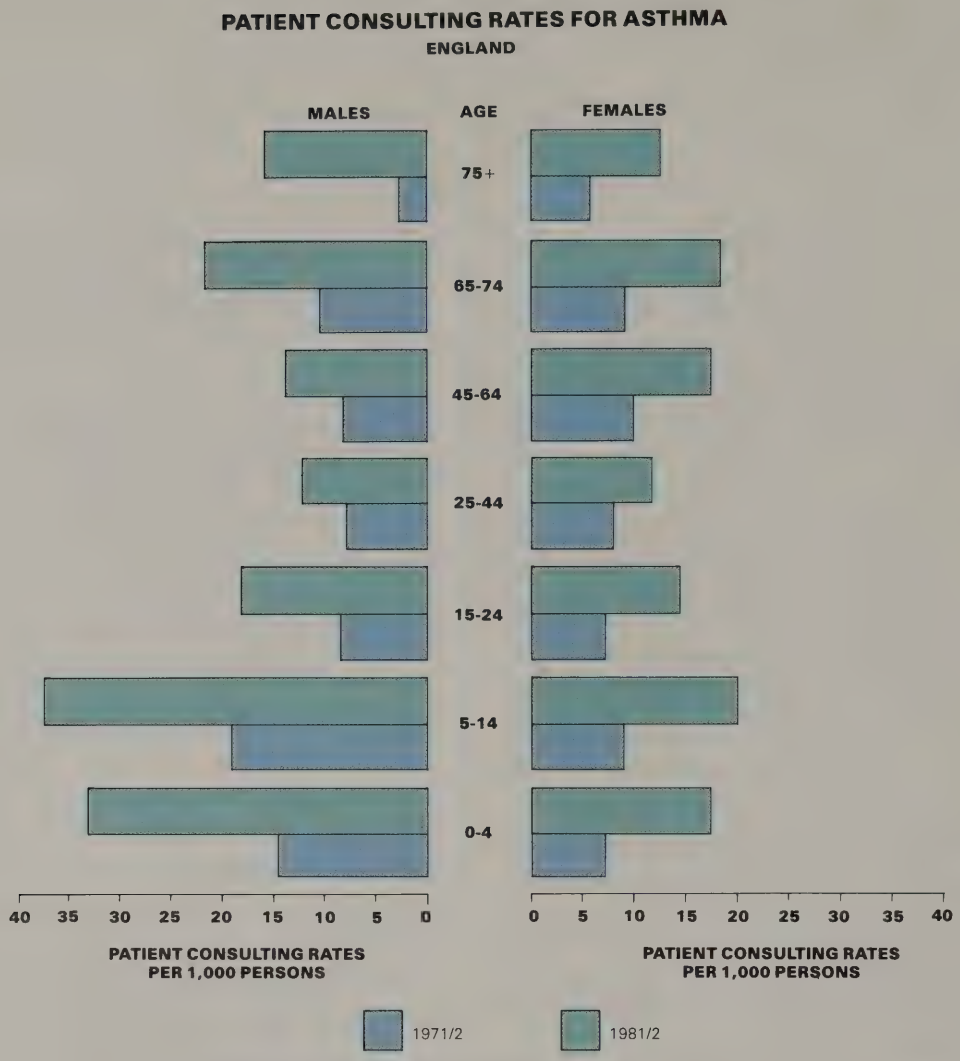


figure O1

use of self management protocols agreed between patient and doctor should have a favourable impact on the burden imposed by asthma on the individual and the community.

POSSIBLE TARGETS

O.9 There are a number of difficulties in the setting of targets – firstly, in the identification of the targets themselves; and secondly, in their quantification. The setting of simple targets related to reductions in mortality is difficult because the factors which lead to death are not sufficiently well understood. Targets should therefore concentrate initially on reducing the amount of avoidable ill-health.

O.10 It may thus be best to develop targets for defined populations based on adherence to published clinical management guidelines, the establishment of agreed protocols between GPs and hospital clinicians, the development of district wide strategies etc. Monitoring the uptake of peak flow meters on prescription and the development of self-management plans may also offer some scope for target development.

O.11 Work will be necessary to establish the linkage between such measures and health outcome. Consultation between the Government, the NHS and other interested parties will be necessary to develop suitable targets.

Environment and Health

BURDENS

P1 The relationships between environmental quality, decent housing and health have long been recognised and environmental standards and pollution control policies have been shaped accordingly. As a result, the acute and gross longer-term effects on health from environmental factors such as pollution have largely been eliminated. Similarly, the provision of housing and the quality of the housing stock in England compares well with other countries although there are still problems, such as poor housing conditions and homelessness in some large cities. Priorities change in the light of new scientific knowledge; previously unrecognised problems emerge and there is a desire for higher levels of safety. Thus, although the general picture is encouraging, there is scope and a need for continuing improvement.

P2 Better environmental quality and good housing can also do much to promote health and well-being. Even where direct effects on health have been eliminated, there are sound health-related reasons for seeking further to improve environmental standards. This is a major theme of the Charter on Environment and Health drawn up by the office of the European Region of the World Health Organisation which was endorsed by the UK and all the other member states in December 1989. The charter includes a section on 'priorities for action' which the Government believes to be a sound basis for action nationally and internationally, although it recognises that the list of priorities is not comprehensive and that there needs to be variations in emphasis in different countries.

P3 The WHO priorities for action are:

- global disturbances to the environment (such as the destruction of the ozone layer and climate change);
- safe and adequate supplies of drinking water;
- safe disposal of sewage;
- the quality of surface, ground, coastal and recreational waters;
- the impacts on the environment and on health of energy production and use, transport and agricultural practices;
- air quality, in particular the oxides of sulphur and nitrogen, photochemical oxidants and volatile organic compounds;
- indoor air quality;
- persistent chemicals;
- hazardous wastes;
- biotechnology, particularly the release of genetically modified organisms;
- contingency planning for accidents and disasters;
- cleaner technologies.

OBJECTIVE

P4 To protect and promote the health and well-being of the nation by improving environmental quality and housing conditions.

SCOPE FOR MEETING THIS OBJECTIVE

P5 The Government's White Paper on the environment "This Common Inheritance" was published in

September 1990. It sets out a strategy for continuing improvement on just such a broad front and it includes many specific targets which are relevant to the WHO priorities. "This Common Inheritance" sets these out in full. A number of the targets most directly relevant to health are set out in the remainder of this Annex. These are existing targets, though it is intended that other targets should be developed. It is not practicable, given the existing state of knowledge, to convert existing targets into targets for health improvement. The Departments of Health and of the Environment will be consulting further about ways of improving understanding of the effects of environmental conditions on human health and well-being, and the implications for these environmental targets.

TARGETS

Drinking water

P6 Adequate supplies of high quality drinking water have long been generally available in this country. These comply with the great majority of standards in national regulations, which implement the EC Drinking Water Directive; and those supplies which do not yet comply in all aspects do not endanger health. Water companies are carrying out major programmes to remedy breaches of the standards;

- By the end of 1995 the current programme of improvements should be completed, thereby remedying most of the breaches of the EC Standards for drinking water.

Bathing waters

P7 Polluted bathing waters and beaches are potentially harmful to health although it is difficult to quantify the risks. There has been a steady improvement in recent years and a major effort has been launched to bring all bathing waters up to standard;

- By 1995 all but a few of identified bathing waters should comply with the EC Bathing Water Directive: the remainder should comply by 1998.

Air quality: Oxides of Nitrogen (NOx) and Photochemical Oxidants

P8 Emissions of oxides of nitrogen (NOx) contribute to acid rain and to photochemical oxidants. The principal sources are large combustion plants such as power stations and vehicles. Action is in hand to reduce emissions from both these sources.

P9 Under certain weather conditions the WHO Guidelines for peak ozone concentration in air is occasionally exceeded in parts of southern England. Solving this problem will require national and international action to reduce emissions of NOx and of volatile organic compounds which are the precursors of this ozone;

- On a 1980 baseline, reduce emissions of NOx from existing large combustion plants by 30% by 1998;
- Reduce NOx levels in urban air on a 1990 baseline by at least 50% by 2000;
- By 2000 effective national and supra-national controls should be in place to ensure that air quality meets the WHO Guideline for peak ozone concentration.

Housing conditions and homelessness

P10 The overall objective of the Government's housing policy is to ensure that decent housing is within reach of all families. Housing policy and programmes continue to give priority to renovation of the housing stock and to securing housing for

those who could not otherwise afford decent housing.

P11 Tackling homelessness is a particular priority, not least because of the damage it can cause to people's physical and mental health and well-being. Two categories are of particular concern: first, single people sleeping rough in the streets (3000 – 5000) particularly in London; and second, families (11,000) living in 'bed and breakfast' accommodation. The Government has introduced special measures to help those sleeping rough in London and to reduce the need for local authorities to use bed and breakfast accommodation; over two years, these are expected to provide 16,000 additional family lettings and over 3,000 extra places in permanent housing and hostels.

CONCLUSION

P12 It is intended that other targets should be developed. Views are invited on the priorities which ought to guide these.

The World Health Organisation European Region Targets "Health For All by the Year 2000"

1 The member states of the European Region of the World Health Organisation (WHO) agreed that, in order to improve the health situation in Europe, efforts should be concentrated on the promotion of healthy lifestyles, the reduction or elimination of preventable diseases, and the provision of comprehensive health coverage for the whole population based on primary health care, particular attention being given to the vulnerable groups in society and a move away from focusing on treating disease to one of avoidance of disease. The strategy is popularly known as "Health for All by the Year 2000" (HFA).

2 To underline commitment to this movement, and to monitor progress, a set of 38 targets was formulated. While they cannot be legally binding on member states, they are intended to help member states set their own targets which will reflect their specific needs, priorities and values. A number of Regional, District and Family Health Services Authorities have already adopted the European Targets framework as a model for their own strategic plans.

3 The targets can be broken down into three subsets:

(a) targets for improvements in health (reducing or eliminating preventable conditions, (childhood diseases); or reducing mortality (from heart disease, cancer, accidents etc);

(b) targets for activities needed to bring about these improvements in health (policies to bring about improvements in lifestyle, eg reducing tobacco consumption, alcohol and drug misuse, reducing environmental health risks and improving the environment);

(c) targets designed to improve the management and organisation of the health services, the quality of care, the training of health workers etc.

4 The member states have been monitoring their progress towards the regional targets. The baseline year for the exercise is 1980. To allow for changes in the age structure of the population over time, mortality rates are expressed as age standardised rates based on the European standard population, as published in the WHO Statistics Annual.

5 The full list of HFA targets and a more detailed account of where England stands in relation to them is set out in the remainder of this appendix.

EQUITY IN HEALTH

1 By the year 2000, the actual differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the levels of health of disadvantaged nations and groups.

There is a persistent gap between death rates among manual and non-manual classes, and the Regional Target of reducing the actual differences in health status between groups within countries by at least 25% by the year 2000 does not seem likely on present evidence to be achieved, at least with respect to these social groups.

There have however been marked reductions in national perinatal and infant mortality rates over the past 10 years in each of the social classes, with some reduction in the disparity between manual and non-manual classes. However, in 1987 the perinatal and infant mortality rates were still more than 50% greater in social class V (unskilled occupations) than social class I (professional occupations).

GENERAL HEALTH AND WELL-BEING

2 By the year 2000, people should have the basic opportunity to develop and use their health potential to live socially and economically fulfilling lives.

3 By the year 2000, disabled persons should have the physical, social and economic opportunities that allow at least for a socially and economically fulfilling and mentally creative life.

4 By the year 2000, the average number of years that people live free from major disease and disability should be increased by at least 10%.

6 By the year 2000, life expectancy at birth in the Region should be at least 75 years.

Life expectancy at birth is currently 75.5 years (72.8 for males and 78.3 for females). England has thus already attained the Regional target for this indicator. Assessment of trends in general health and well-being is hampered to some extent by lack of appropriate data. Recent trends in self-reported morbidity as collected in the General Household Survey have indicated that, although between 1980 and 1989 there was little change in the prevalence of "acute sickness", there was some evidence that the rates of self-reported longstanding illness had increased during the 1980s.

Using the General Household Survey measure of limiting longstanding illnesses, which is sometimes used as a proxy for disability, it has been shown that, in England and Wales, over the ten year period from 1976 to 1985, while the expectation of life increased, the expectation of life without disability changed little. This was true for both men and women. These findings may simply reflect changing perceptions of illness or a greater propensity to report it, but they do emphasise the importance of considering trends not only in life expectancy, but also those which reflect the quality of life.

COMMUNICABLE DISEASES

5 By the year 2000, there should be no indigenous measles, poliomyelitis, neonatal tetanus, congenital rubella, diphtheria, congenital syphilis or indigenous malaria in the Region

England compares well with most other European countries and is making satisfactory progress towards the European targets for the eradication of childhood

diseases. Over the last five years there have been no indigenous cases of poliomyelitis caused by wild poliomyelitis virus. Cases of diphtheria are either imported or cutaneous. There has also been a declining trend in the number of measles cases although the elimination of the disease will require a sustained vaccination uptake of at least 95% (the uptake for the year ending 31 March 1990 was 90%). The introduction of measles, mumps and rubella (MMR) vaccinations should be reflected in further reductions in the incidence of measles cases. Figures on reported cases of congenital rubella syndrome show a continuing decline. Cases of congenital syphilis have fallen by 61% from 119 in 1980 to 46 in 1987. The appointment of named immunisation co-ordinators in every District Health Authority in England has helped to improve the management of the immunisation programme and will continue to contribute significantly to improving uptake.

INFANT AND MATERNAL MORTALITY

7 **By the year 2000, infant mortality in the Region should be less than 20 per 1000 live births.**

8 **By the year 2000, maternal mortality in the Region should be less than 15 per 100,000 live births.**

Infant mortality in 1989 was 8.4 deaths per 1,000 live births. England is one of the European countries that has already achieved the Regional target, although, in 1986/87, eleven out of 28 European member states for which data are available had lower infant mortality rates; some substantially lower than the target. The maternal mortality rate was 6.1 per 100,000 live births in 1988. This is well below the Regional target.

CARDIOVASCULAR DISEASE

9 **By the year 2000, mortality in the Region from diseases of the circulatory system in people under 65 should be reduced by at least 15%.**

Between 1980 and 1989, the death rate from diseases of the circulatory system in the population in England under 65 years of age fell from 120.5 per 100,000 to 85.4 per 100,000 population. This represents a reduction of 29%, which already exceeds the reduction of at least 15% from the 1980 baseline. This decline reflects falls in mortality for both ischaemic heart disease (27% decline) and cerebrovascular disease (32% decline).

CANCER

10 **By the year 2000, mortality in the Region from cancer in people under 65 should be reduced by at least 15%.**

The death rates from malignant neoplasms in the under 65 age group declined by 8% in the period between 1980 and 1989, the decline being greater in males than females. Amongst males, the mortality rate for lung cancer – which accounts for about a third of all deaths from malignant neoplasm in the under 65 age group – has fallen by 29%, declines having occurred in each of the ten year age groups between the ages of 25 and 64 years. Amongst females – where lung cancer accounts for about 15% of all deaths from malignant neoplasm – there has been little change in the mortality rate over the decade. Differing age and sex trends are attributable to different smoking patterns in the past – reductions in smoking rates among women have occurred later than in men. Amongst women, between 1980 and 1989 there was a 5% decline in mortality from all

malignant neoplasms. Cervical cancer diminished by 20% but there was little change in breast cancer mortality, which accounts for over one quarter of all cancer deaths in the under 65 age group.

ACCIDENTS

11 **By the year 2000, deaths from accidents in the Region should be reduced by at least 25% through an intensified effort to reduce traffic, home and occupational accidents.**

Mortality from all external causes of injury and poisoning, and particularly from motor vehicle traffic accidents, is one of the lowest in Europe. There has been a 19% fall in the overall category, including 24% fall in accident mortality in England over the past nine years.

SUICIDE

12 **By the year 2000, the current rising trends in suicides and attempted suicides in the Region should be reversed.**

Although the Regional target recommendation of a reversal in current rising trends in suicides is being achieved – the overall suicide rate declined by 18% between 1980 and 1989 – differing trends have occurred by age and sex. During this period, the suicide rate fell by only 1.4% in males but 46% in females. Amongst males a rise occurred in young adults, particularly in males age 20-24 years (71% rise in the period 1980-1989).

LIFESTYLES

13 **By 1990, national policies in all member states should ensure that legislative, administrative and economic mechanisms provide broad intersectoral support and resources for the promotion of healthy lifestyles and ensure effective participation of the people at all levels of such policy-making.**

14 **By 1990, all member states should have specific programmes which enhance the major roles of the family and other social groups in developing and supporting healthy lifestyles.**

15 **By 1990, educational programmes in all member states should enhance the knowledge, motivation and skills of people to acquire and maintain health.**

16 **By 1995, in all member states, there should be significant increases in positive health behaviour, such as balanced nutrition, non-smoking, appropriate physical activity and good stress management.**

17 **By 1995, in all member states, there should be significant decreases in health-damaging behaviour, such as overuse of alcohol and pharmaceutical products; use of illicit drugs, and dangerous chemical substances; dangerous driving and violent social behaviour.**

Although there has been a discernible improvement in the awareness of the population as to what constitutes a healthy lifestyle, much remains to be done. In areas where overall encouraging trends have occurred, such as smoking, diet and road traffic accidents, further improvement is required and in a number of areas related to health-damaging behaviour, such as alcohol misuse and drug abuse, there has been no improvement so far.

SMOKING

The prevalence of cigarette smoking in adults in England has continued to fall. In 1980, 61% of the population were non-smokers. By 1988 that figure had risen to 68%. Reductions in smoking rates among

women have been slightly smaller than in men, and smoking among teenage boys and girls, and women in their early twenties, has declined more slowly than at older ages.

HEALTHY DIET

As far as the national diet is concerned, there has been an improvement in nutritional quality; the diet contains less fat, saturated fatty acids and energy, mainly due to a decline in consumption of red meat (decline by over 25%) and full fat dairy products, and an increase in fibre, white meat, reduced fat milks and fruit. The main problem is that saturated fatty acid consumption still supplies about 17% of energy on average, compared to the Department of Health's target of 15% maximum. Fat consumption still accounts on average for 42% of total energy intake, well above the Department's recommendation of 35% maximum. The ratio of polyunsaturated to saturated fatty acids, however, has risen to 0.37, in the direction which would result from achievement of the Department's targets.

PHYSICAL ACTIVITY

Although participation in sport and recreational physical activity has increased over the last decade, it is still a minority activity. In 1986, 46% of adults reported participating in at least one such indoor or outdoor activity in the four weeks before interview in the General Household Survey; 57% of men reported some physical activity in 1986, compared with 53% in 1980; for women participation had increased from 33% in 1980 to 37% in 1986. Women's participation in indoor activities increased sharply over this period, but their participation in outdoor activities showed no change. In addition to the increase in participation rates between 1980 and 1986, there was also some increase in the number of occasions that each person participated. The most popular activity was walking, which accounted for about a third of all occasions.

ALCOHOL

Alcohol consumption in the United Kingdom (UK) fell in 1981 and 1982 but has since risen steadily, and annual consumption in 1988, at 9.3 litres of alcohol per head of population aged 15 years and over, exceeded that in 1980 (9.0 litres). Over this period, there is some evidence of a fall in men's consumption but a rise in women's consumption – which is, however, still much lower than that of men. Between 1970 and 1988 alcohol consumption per head rose by nearly 40% .

ILLICIT DRUG USE AND OVERUSE OF PHARMACEUTICAL PRODUCTS

The number of notified new and former addicts has risen from 2,233 in 1980 to 13,700 in 1989, representing a six-fold rise. The 1989 figure includes re-notified addicts who were not included in the 1980 count, which was an underestimate. There has also been a three-fold rise in deaths from solvent abuse from 26 in 1980 to 87 in 1987. With regard to prescribed drugs there has been a 22% drop in the number of prescriptions in general practice for benzodiazepines over the nine-year period 1980 to 1988 (23.912 million in 1980 to 18.682 million in 1988).

ENVIRONMENT

18 **By 1990, member states should have multisectoral policies that effectively protect the human environment**

from health hazards, ensure community awareness and involvement, and effectively support international efforts to curb such hazards affecting more than one country.

19 **By 1990, all member states should have adequate machinery for the monitoring, assessment and control of environmental hazards which pose a threat to human health, including potentially toxic chemicals, radiation, harmful consumer goods and biochemical agents.**

20 **By 1990, all people of the Region should have adequate supplies of safe drinking water, and by the year 1995 pollution of rivers, lakes and seas should no longer pose a threat to human health.**

21 **By 1995, all people of the Region should be effectively protected against recognised health risks from air pollution.**

22 **By 1990, all member states should have significantly reduced health risks from food contamination and implemented measures to protect consumers from harmful additives.**

23 **By 1995, all member states should have eliminated major known health risks associated with the disposal of hazardous wastes.**

24 **By the year 2000, all people of the Region should have a better opportunity of living in houses and settlements which provide a healthy and safe environment.**

25 **By 1995, people of the Region should be effectively protected against work-related health risks.**

The Regional targets recommend that member states should have policies that effectively protect the human environment from health hazards and adequate machinery for monitoring and controlling such hazards. Adequate supplies of safe drinking water, effective protection against recognised health risks for air pollution, and the removal of threat to human health from pollution of rivers, lakes and seas are likewise recommended. On environmental issues, England has satisfied the targets requiring policies that effectively protect the human environment from health hazards and adequate machinery for monitoring and controlling such hazards. Effective mechanisms are in place to control water and air pollution and waste management.

TOXIC CHEMICALS

Monitoring, assessment and control of environmental hazards due to toxic chemicals have been subject to regulatory mechanisms for many years. Notification and assessment schemes for new chemicals prior to placing them on the market were introduced in 1983 and stricter controls on pesticides in 1986. Regulations to control chemicals in the workplace have likewise been introduced.

WATER POLLUTION

The population has ready access to safe drinking water. The Water Act 1989 has set statutory limits defining "wholesome water" and it also changes the regime for controlling the water quality of rivers, lakes and coastal waters.

AIR POLLUTION

The Government intends action on air quality to be increasingly based on the definition of acceptable standards for the protection of health and the wider environment. Statutory standards in Britain already exist, backed by European Community Directives, for smoke, sulphur dioxide, lead in air and nitrogen dioxide. These are now met in all but a very few areas.

and the Government is committed to ensuring full compliance as soon as possible. The Government is also encouraging the establishment of European Community guidelines for ground level ozone concentrations and is establishing an expert panel to advise on further air quality standards. Meanwhile, sulphur dioxide and smoke emissions have continued to decline with falls of 24% and 10% respectively between 1980 and 1989, and estimated lead emissions from petrol engined vehicles have fallen by 65% between 1980 and 1989, and the unleaded petrol share of the total petrol market is now approaching 40%, following a publicity campaign and the introduction and progressive increase of fiscal incentives. Tighter European standards on new car emissions, operative from 1992, will help curb the rising trend of emissions of carbon monoxide, nitrogen oxides and volatile organic compounds.

HOUSING

The Government's housing policy aim is to put decent housing within reach of all families. The quality of the housing stock has continued to improve steadily, mainly through private investment, but assisted by Government-financed slum clearance, renovation grants to private owners, and construction of subsidised housing. The main focus of housing policy is on providing enough subsidised rented housing for households who need it; special programmes exist to reduce the need for families to be temporarily housed in often unsatisfactory bed and breakfast accommodation, and to provide housing for single people sleeping rough in London.

WASTE MANAGEMENT

Legislation is in place to ensure the safe disposal of hazardous wastes. A system of "integrated pollution control" for the most polluting sectors of industry is being introduced and will be enforced by a strengthened pollution inspectorate. A major effort has also been made to clean up those coastal waters which have been affected by poorly sited sewage outfalls.

APPROPRIATE CARE

26 **By 1990, all member states, through effective community representation, should have developed health care systems that are based on primary health care and supported by secondary and tertiary care as outlined in the Alma-Ata Conference.**

27 **By 1990, in all member states, the infrastructures of the delivery systems should be organised so that resources are distributed according to need, and that services ensure physical and economic accessibility and cultural acceptability to the population.**

28 **By 1990, the primary health care system of all member states should provide a wide range of health-promotive, curative, rehabilitative and supportive services to meet the basic health needs of the population and give special attention to high risk, vulnerable and underserved individuals and groups.**

29 **By 1990, in all member states, primary health care systems should be based on co-operation and teamwork between health care personnel, individuals, family and community groups.**

30 **By 1990, all member states should have mechanisms by which the services provided by all sectors relating to health are co-ordinated at the community level in the primary health care system.**

31 **By 1990, all member states should have built effective mechanisms for ensuring quality of patient care within their health care systems.**

The Regional targets recommend that the primary health care system, based on teamwork, should provide a wide range of health-promotive, curative, rehabilitative and support services to the population, and should give special attention to high risk, vulnerable and neglected groups. Effective mechanisms for ensuring quality of patient care also feature prominently in this group of targets.

England has in place an established primary health care system based on teamwork, which already meets these targets, as well as existing statutory and management mechanisms to ensure that District Health Authorities, Family Health Services Authorities and Local Authorities co-ordinate action at community level. Several mechanisms exist for assessing quality of care and health technologies within the health service. Rapid progress is being made in implementing medical audit systems in hospital, community, and general practice following the stress laid on it in the White Paper "Working for Patients." The use of performance indicators, health service audit techniques and measures of value for money are all intended to promote better and more efficient use of resources. The aim is to maintain and improve the health service so that patients can receive the best possible care within the limits of the available resources.

HEALTH DEVELOPMENT SUPPORT

32 **Before 1990, all member states should have formulated a research strategy to stimulate investigations which improve the application and expansion of knowledge needed to support their national "Health For All" developments.**

33 **Before 1990, all member states should ensure that their health policies and strategies are in line with "Health For All" principles and that national legislation and regulations make their implemention effective in all sectors of society.**

34 **Before 1990, member states should have a managerial process for health development geared to the attainment of "Health For All" actively involving communities and all sectors relevant to health, accordingly ensuring preferential allocation of resources to health development priorities.**

35 **Before 1990, member states should have health information systems capable of supporting their national strategies for "Health For All".**

36 **Before 1990, in all member states, the planning, training and use of health personnel should be in accordance with "Health For All" policies, with emphasis on the primary health care approach.**

37 **Before 1990, in all member states, education should provide personnel in sectors related to health with adequate information on national "Health For All" policies and programmes and their practical application to their sectors.**

38 **Before 1990, all member states should have established a formal mechanism for the systematic assessment of the appropriate use of health technologies and of their effectiveness, efficiency, safety and acceptability, as well as reflecting national policy and economic restraints.**

This group of targets recommends the establishment of a managerial process for health development ensuring preferential allocation of resources to health development priorities, efficient information systems, and the remodelling of health personnel training to emphasise the primary health care approach.

MANAGERIAL PROCESS FOR HEALTH FOR ALL

A managerial process for health development ensuring preferential allocation of resources is an established feature of the administration of the health services. Information technology has been, and is continuing to be, developed and introduced to support the efficient and effective operation of the health services. Record linkages are also now an established feature. In the past, changes in medical education have taken place in only a very patchy manner. However, the introduction of the post-graduate education allowance for GPs, and the earmarking of specific resources for post-graduate and continuing medical and dental education will ensure future planning and training for the professions is in line with Health For All policies. The nursing profession has adopted a strategy which encompasses planning, training and the use of nursing personnel in line with Health for All policies and the primary health care approach.

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